

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Gardnerville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1573 South Muller Pkwy Gardnerville, NV 89410	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review the facility failed to ensure a device evaluation was completed and consent obtained prior to placing a resident's mattress on the floor for 1 of 24 residents sampled related to Facility Reported Incidents (FRIs). This deficient practice had the potential to deprive a resident/resident representative of the right to be informed of the risks and benefits of an intervention which could restrict the resident's freedom of movement.</p> <p>Findings include:</p> <p>Resident #45</p> <p>Resident #45 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy and idiopathic normal pressure hydrocephalus.</p> <p>A final report for FRI #NV00073587, documented an allegation of neglect was substantiated by the facility when a Licensed Practical Nurse (LPN) placed Resident #45's mattress on the floor.</p> <p>A witness statement provided by a Certified Nursing Assistant (CNA), dated 03/05/2025, documented the LPN took Resident #45's bed frame away and placed the resident's mattress on the floor on 02/20/2025.</p> <p>An Interdisciplinary Note dated 03/07/2025, written by the Lead Administrator of Nevada (LAN), documented the LAN spoke with Resident #45's family member regarding an allegation of neglect. The resident's family member reported concern the resident's mattress was placed on the floor.</p> <p>On 05/01/2025 at 11:09 AM, the LAN affirmed the LAN conducted the investigation into the allegations of abuse and neglect of Resident #45.</p> <p>On 05/01/2025 at 4:13 PM, during an interview with the Director of Nursing (DON), the Regional Director of Clinical Operations (RDCO), and the LAN, the DON verbalized an in-service was provided to all staff related to abuse and neglect and reporting requirements. After the in-service training, the CNA explained what the CNA had witnessed related to Resident #45's mattress being placed on the floor by an LPN. The resident had been discharged by the time the allegation was reported by the CNA.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The LAN explained, after completing an investigation, the facility substantiated the allegation of neglect. The LAN verbalized the LAN spoke to Resident #45's family member over the phone. During the phone call, the family member confirmed and expressed being unhappy about the resident's mattress being placed on the floor. The LAN explained the facility determined the LPN's actions were neglectful based on a lack of a barrier between the floor and the resident's mattress, the LPN not notifying anyone prior to placing the mattress on the floor, and it was a restraint. The mattress on the floor acted as a restraint due to the resident's inability to get up from the floor unassisted. Prior to placing the mattress on the floor, the resident had been able to get out of bed independently. The LAN verbalized the LPN initiated the use of a restraint without notifying the physician or doing a device evaluation.</p> <p>The facility policy titled Physical Restraints and Enablers/Devices, updated 01/2025, documented residents had the right to be free from any physical restraints imposed for purposes of discipline or staff convenience and not required to treat the resident's medical symptoms. A physical restraint was defined as any manual method, physical or mechanical device, equipment or material attached or adjacent to the resident's body which met all of the following: was attached or adjacent to the resident's body, could not be removed easily by the resident, and restricted the resident's freedom of movement or normal access to the resident's body. A device evaluation was to be completed prior to the device being initiated, annually, and on any change in condition. The effect, not the intent, of the device was evaluated to determine if the device used was a restraint or an enabler. If the device was restraining, the physician would be contacted for an order indicating specific type of device, reason for use, and duration of use. The resident/resident representative would be provided with risks and benefits of restraint use or device use, and consent would be obtained prior to implementation.</p> <p>FRI #NV00073587</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a Licensed Practical Nurse (LPN) treated a resident with dignity and did not seclude the resident, leaving the resident only in a brief and a t-shirt in the dining room while experiencing behaviors for 1 of 24 residents sampled related to facility reported incidents (FRI) (Resident #43). This deficient practice had the potential to result in the resident experiencing psychosocial harm or emotional distress due to not being treated with respect and dignity.</p> <p>Findings include:</p> <p>Resident #43</p> <p>Resident #43 was admitted to the facility on [DATE] and readmitted on [DATE], and discharged on 03/12/2025, with diagnoses including unspecified dementia, severe with other behavioral disturbance, anxiety disorder, unspecified, cognitive communication deficit, other seizures, and difficulty in walking, not elsewhere classified.</p> <p>A FRI, dated 03/06/2025, documented a Certified Nursing Assistant (CNA) entered Resident #43's room to assist the resident with a brief change. The resident became verbally agitated and began to exhibit signs of psychosis, signaling a Licensed Practical Nurse (LPN) to go to the resident's room to see what was happening. The CNA removed Resident #43 from the resident's room and transferred the resident to the community dining room. The resident had a soiled brief and was only wearing a t-shirt. The curtains were drawn back to allow view of the resident in the dining room, staff left the dining room and closed the door, and observed the resident through the windows of the dining room.</p> <p>The final report from the facility, dated 03/10/2025, documented the facility had terminated three employees for a policy violation as a result of the incident.</p> <p>A Nursing Progress Note dated 03/04/2025, documented staff heard loud screaming coming from the 200 hallway. An LPN had asked the resident what was wrong and the resident replied there were people trying to kill the resident and requested a Sheriff to come to the facility. The resident began yelling for help. The LPN attempted to de-escalate the resident's behaviors and was unsuccessful. The resident began to throw items in the resident's room toward the roommates side of the room. A CNA approached Resident #43 to try and calm the resident and the resident began to grab at the CNAs arms, causing scratches and bleeding to the CNAs arms. The LPN intervened and was able to unleash the resident's grip on the CNAs arms. The resident then grabbed the call light and was attempting to strike staff with the call light. The resident was assisted to the resident's wheelchair and removed from the room to the dining room as a behavioral intervention.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>While in the dining room, the resident attempted to rip the television from the wall, took the cord from the television, was swinging the cord toward staff, and threw the television remote control toward staff while stating the resident was going to tear stuff up. The LPN offered food and drink to the resident to calm the resident and the resident declined. The resident escalated by throwing items from drawers and hitting the LPN. The LPN offered medications to the resident and the resident accepted. The resident began to calm down after administration of the medications and was returned to the resident's room to be placed in bed.</p> <p>A Care Plan initiated on 03/06/2025, documented the resident experienced a behavioral episode and was taken to the common room and left there with the door closed.</p> <p>A Social Services progress note, dated 03/10/2025, documented the resident could not recall the incident and had no emotional concerns.</p> <p>On 05/01/2025 at 1:13 PM, the Director of Nursing (DON) verbalized a CNA was trying to change Resident #43's brief when the resident started to yell at the CNA. An LPN arrived at the resident's room and the CNA had told the LPN the resident was yelling at the CNA and was falsely accusing the CNA of things. The DON explained the resident was hallucinating and saying crazy things. The resident was very upset and was saying things like they're trying to kill me. The LPN was trying to reassure the resident no one was there to kill the resident. The resident then began to throw things and had grabbed a CNA. The LPN was attempting to tell the resident it was ok to get the resident to release the CNA. The resident then grabbed the call light cord and was swinging it around. The DON explained the resident was removed from the resident's room and taken to the dining room for safety reasons. The resident was closed in the dining area while still experiencing hallucinations. The resident was in only a soiled brief and a t-shirt while in the dining area with all of the curtains drawn back to view the resident. Once the resident was calm, the resident was taken back to the resident's room.</p> <p>The DON confirmed all curtains were open to the dining room, exposing the resident to all elements, while only wearing a soiled brief and a t-shirt, and experiencing an episode of behaviors. The DON confirmed the situation was handled poorly by staff and the resident's dignity was disrespected by leaving the resident in a soiled brief and a t-shirt in a common area of the facility.</p> <p>The facility document titled Notice of Resident Rights Under Federal Law, last updated November 2026, documented the resident had the right to a dignified existence, right to be treated with respect and dignity, and the right to be free from involuntary seclusion.</p> <p>The facility document titled Resident Rights, undated, documented a resident in the facility would have the right to be treated with respect and dignity.</p> <p>FRI #NV00073619</p> <p>Cross reference tags F603 and F943</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to protect 1 of 24 residents sampled for Facility Reported Incidents (FRI) free from involuntary seclusion. The deficient practice had the potential to cause the resident psychosocial harm or emotional distress by placing the resident alone in the common dining room, closing the door, and leaving the resident isolated from others.</p> <p>Findings include:</p> <p>Resident #43</p> <p>Resident #43 was admitted to the facility on [DATE] and readmitted on [DATE], and discharged on 03/12/2025, with diagnoses including unspecified dementia, severe with other behavioral disturbance, anxiety disorder, unspecified, cognitive communication deficit, other seizures, and difficulty in walking, not elsewhere classified.</p> <p>A FRI, dated 03/06/2025, documented a Certified Nursing Assistant (CNA) entered Resident #43's room to assist the resident with a brief change. The resident became verbally agitated and began to exhibit signs of psychosis, signaling a Licensed Practical Nurse (LPN) to go to the resident's room to see what was happening. The CNA removed Resident #43 from the resident's room and transferred the resident to the community dining room. The resident had a soiled brief and was only wearing a t-shirt. The curtains were drawn back to allow view of the resident in the dining room, staff left the dining room and closed the door, and observed the resident through the windows of the dining room.</p> <p>The final report from the facility, dated 03/10/2025, documented the facility had terminated three employees for a policy violation as a result of the incident.</p> <p>A Nursing Progress Note dated 03/04/2025, documented staff heard loud screaming coming from the 200 hallway. An LPN had asked the resident what was wrong and the resident replied there were people trying to kill her and requested a Sheriff come to the facility. The resident began yelling for help. The LPN attempted to de-escalate the resident's behaviors and was unsuccessful. The resident began to throw items in the resident's room toward the roommates side of the room. A CNA approached Resident #43 to try and calm the resident and the resident began to grab at the CNAs arms, causing scratches and bleeding to the CNAs arms. The LPN intervened and was able to unleash the resident's grip on the CNAs arms. The resident then grabbed the call light and was attempting to strike staff with the call light. The resident was assisted to the resident's wheelchair and removed from the room to the dining room as a behavioral intervention.</p> <p>While in the dining room, the resident attempted to rip the television from the wall, took the cord from the television, was swinging the cord toward staff, and threw the television remote control toward staff while stating the resident was going to tear stuff up. The LPN offered food and drink to the resident to calm the resident and the resident declined. The resident escalated by throwing items from drawers and hitting the LPN. The LPN offered medications to the resident and the resident accepted. The resident began to calm down after administration of the medications and was returned to the resident's room to be placed in bed.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Care Plan initiated on 03/06/2025, documented the resident was experienced a behavioral episode and was taken to the common room and left there with the door closed.</p> <p>A Social Services progress note, dated 03/10/2025, documented the resident could not recall the incident and had no emotional concerns.</p> <p>On 05/01/2025 at 1:13 PM, the Director of Nursing (DON) verbalized a CNA was trying to change Resident #43's brief when the resident started to yell at the CNA. An LPN arrived at the resident's room and the CNA had told the LPN the resident was yelling at the CNA and was falsely accusing the CNA of things. The DON explained the resident was hallucinating and saying crazy things. The resident was very upset and was saying things like they're trying to kill me. The LPN was trying to reassure the resident no one was there to kill the resident. The resident then began to throw things and had grabbed a CNA. The LPN was attempting to tell the resident it was ok to get the resident to release the CNA. The resident then grabbed the call light cord and was swinging it around. The DON explained the resident was removed from the resident's room and taken to the dining room for safety reasons. The resident was closed in the dining area while still experiencing hallucinations. The resident was in only a soiled brief and a t-shirt while in the dining area with all of the curtains drawn back to view the resident. Once the resident was calm, the resident was taken back to the resident's room.</p> <p>The DON confirmed all curtains were open to the dining room, exposing the resident to all elements, while only wearing a soiled brief and a t-shirt, and experiencing an episode of behaviors. The DON confirmed the resident was closed in the dining room, isolated from other individuals in the community, and the situation was handled poorly by staff. The DON mentioned not being able to speak on behalf of the resident as to how the resident would feel about the situation because the resident could not recall the incident.</p> <p>The facility document titled Notice of Resident Rights Under Federal Law, last updated November 2026, documented the resident had the right to a dignified existence, right to be treated with respect and dignity, and the right to be free from involuntary seclusion.</p> <p>The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, last updated March 2025, documented residents had the right to be free from abuse, including verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, misappropriation of resident property, exploitation, and any physical or chemical restraint not required to treat the resident's medical condition.</p> <p>Involuntary seclusion was defined as the separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative. Involuntary seclusion included confinement, restriction or isolation of a resident, and may be a result of staff convenience, or may be used to discipline a resident for wandering, yelling, repeatedly requiring care or services, or refusing to allow care.</p> <p>In addition, some abuse or neglect situations may be difficult to determine the outcome of psychosocial outcomes to a resident and it would be appropriate for staff to consider how a reasonable person in the resident's position would be impacted by the incident.</p> <p>FRI #NV00073619</p> <p>(continued on next page)</p>		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference with F tags 550 and 943

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>An initial report for FRI #NV00073619, with an allegation a Certified Nursing Assistant was verbally abusive toward a resident was submitted to the SA on 03/06/2025. A review of progress notes related to the incident revealed the incident occurred on 03/04/2025.</p> <p>Based on interview and document review, the facility failed to ensure an allegation of abuse, neglect and a fall resulting in serious bodily injury was reported to the State Agency (SA) within the required time frame for 7 of 10 Facility Reported Incidents (FRI). This deficient practice could result in allegations of abuse and neglect not being investigated by the facility and/or the SA timely.</p> <p>An initial report for FRI #NV00073584, with an allegation of Resident-to-Resident physical abuse was submitted to the SA on 03/03/2025. The report documented the alleged incident occurred on 02/25/2025.</p> <p>A resident grabbed another resident's shoulders and shook them to wake them up.</p> <p>An initial report for FRI #NV00073594, with an allegation of Resident-to-Resident sexual abuse was submitted to the SA on 03/03/2025. The report documented the alleged incident occurred on 02/27/2025.</p> <p>A resident touched another resident's breasts and neck while the resident was sleeping.</p> <p>An initial report for FRI #NV00073595, with an allegation of Resident-to-Resident physical abuse was submitted to the SA on 03/04/2025 at 12:10 PM. The report documented the alleged incident occurred on 03/04/2025 at 5:55 AM.</p> <p>A resident intentionally wheeled their wheelchair into another resident's bed.</p> <p>An initial report for FRI #NV00073746, with an allegation of neglect was submitted to the SA on 03/20/2025. The report documented the alleged incident occurred on 03/19/2025.</p> <p>A resident fell from their wheelchair resulting in a hip fracture.</p> <p>An initial report for FRI #NV00073802, with an allegation of Resident-to-Resident verbal abuse was submitted to the SA on 03/26/2025. The report documented the alleged incident occurred on 03/25/2025.</p> <p>A resident was verbally aggressive with their roommate.</p> <p>An initial report for FRI #NV00073587, with an allegation of employee-to-resident physical and verbal abuse was submitted to the SA on 03/03/2025.</p> <p>The facility's investigation into the allegations included a typed interview with a CNA documenting the alleged incidents of abuse occurred on 02/20/2025 and 02/27/2025.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/01/2025 at 4:09 PM, during an interview with the Director of Nursing (DON), the Lead Administrator of Nevada (LAN), the Regional Director of Clinical Operations (RDCO) and the interim Executive Director (ED), the DON verbalized the facility's process for reporting allegations of abuse, neglect and exploitation included staff reporting to facility leadership immediately and the facility reporting the allegation to the SA within two hours.</p> <p>The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 03/2025, documented each resident had the right to be free from abuse, including verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, misappropriation of resident property, exploitation, and any physical or chemical restraint not required to treat the resident's medical condition. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also included deprivation of goods or services necessary to attain or maintain physical, mental and psychosocial wellbeing. The facility would immediately report all suspected and/or allegations of abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law.</p> <p>The facility policy titled Abuse Reporting and Response, updated 10/2022, documented the facility was to report all suspected and/or allegations of abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law. The Executive Director or designee would report alleged violations to the state survey agency and other officials in accordance with state law as follows: allegations involving abuse or resulting in serious bodily injury were to be reported immediately but no later than two hours, all allegations not involving abuse and which did not result in serious bodily injury were to be reported immediately but no later than 24 hours.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on interview and document review, the facility failed to ensure initial elder abuse prevention training was completed timely for an agency contracted Certified Nursing Assistant (CNA) involved in and terminated as a result of an abuse investigation (Employee #24). This deficient practice had the potential to place all residents at risk for abuse and neglect.</p> <p>Findings include:</p> <p>Employee #24</p> <p>Employee #24 was hired by the facility on 11/08/2024, and terminated on 03/05/2025, as a CNA.</p> <p>Employee #24's personnel record lacked documented evidence the employee had completed initial elder abuse training upon hire.</p> <p>A Facility Reported Incident (FRI), dated 03/06/2025, documented a Certified Nursing Assistant (CNA) entered Resident #43's room to assist the resident with a brief change. The resident became verbally agitated and began to exhibit signs of psychosis, signaling a Licensed Practical Nurse (LPN) to go to the resident's room to see what was happening. The CNA removed Resident #43 from the resident's room and transferred the resident to the community dining room. The resident had a soiled brief and was only wearing a t-shirt. The curtains were drawn back to allow view of the resident in the dining room, staff left the dining room and closed the door and observed the resident through the windows of the dining room.</p> <p>The final report from the facility, dated 03/10/2025, documented the facility had terminated three employees for a policy violation as a result of the incident.</p> <p>On 05/01/2025 at 1:13 PM, the Director of Nursing explained Employee #24 had been involved in an abuse investigation on 03/06/2025, and the CNAs employment was terminated as a result.</p> <p>On 05/01/2025 at 3:35 PM, the Administrator confirmed Employee #24 lacked initial elder abuse training completion upon hire and verbalized there was no proof the employee had completed elder abuse training during employment with the facility. The Administrator explained all staff, including agency contracted staff, were required to complete elder abuse training upon hire.</p> <p>The facility policy titled Abuse Training, last updated October 2022, documented all staff were to complete abuse training upon hire and annually thereafter.</p> <p>FRI #NV00073619</p> <p>Cross reference F tags 550 and 603</p>		