STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295082	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardnerville Health & Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure a resident remained free from verbal abuse when a Certified Nursing Assistant (CNA) used an elevated tone, and reˆentered the resident's room after being removed for 1 of 52 residents (Resident #23). This deficient practice had the potential to put residents at risk for emotional harm. Findings include:Resident #23 Resident #23 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including need for assistance with personal care, atrial fibrillation, anxiety disorder and cognitive communication deficit. On 06/22/2026 at 4:03 PM, survey staff heard Resident #23 verbalize, I am going to report this. The resident sounded distressed and upset. CNA1 verbalized they were explaining a matter with Resident #23. A new CNA entered the room and informed CNA1 that they had the situation handled. On 06/24/2026 at 2:52 PM, CNA2 verbalized on 06/22/2026 the resident wanted the food cut up. When CNA2 entered the room, CNA1 appeared stressed and exited the room. CNA1 returned and leaned on the resident's table, stating, I told you CNA2 was going to come in, and was again instructed by CNA2 to leave the room. CNA2 did not feel the tone was appropriate and notified the Scheduler/CNA who notified the Administrator. On 06/25/2026 at 10:41 AM, Resident #23 verbalized not recalling exactly what CNA1 said during the encounter. The resident verbalized CNA1 yelled and behaved in an intimidating manner. The resident confirmed CNA1 returned and stated, I hope you don't make me leave. The resident reported not feeling good when the CNA1 yelled and became upset. The resident reported CNA1 had not returned since the incident occurred. The resident reported not being fearful of remaining in the facility and reported no previous similar incidents. On 06/25/2026 at 11:08 AM, the Scheduler/CNA, verbalized abuse could include physical, verbal, failure to change a resident timely, withholding services, and not providing proper care such as bathing or turning. The Scheduler/CNA was not present for the incident on 06/22/2026; however, it was reported to the Scheduler/ CNA Resident #23 pressed the call light and CNA1 answered. The resident informed CNA1 that assistance was needed with changing and CNA1 stated they would return shortly. Resident #23 then yelled at CNA1 stating CNA1 always turned off the call light and never returned. CNA1 responded to the resident in an elevated tone, which the Scheduler/CNA described as inappropriate. CNA2 provided the required care to Resident #23 and removed CNA1 from the situation. The incident was reported to the Administrator to initiate a Facility Reported Incident investigation. CNA1 was suspended pending further review. The Abuse Coordinator and Social Worker followed up with Resident #23 to ensure the resident felt safe and was free from emotional distress. The facility's investigation conducted from 06/22/2026 - 06/26/2026, documented Assessments were conducted on the hall to ensure no additional concerns were present with other residents. All residents verbalized feeling safe in the facility. The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property and Exploitation, updated 03/2025, documented verbal abuse may be a type of mental abuse. Verbal abuse includes the use of oral, written or gestured communication or sounds to residents within hearing distance regardless of age, ability to comprehend or disability. Examples of mental and verbal abuse include yelling or hovering over a resident with the intent to intimidate.

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure care plans were developed related to 1) the monitoring and supervision of high-risk medications including narcotics and diuretics, 2) the care of indwelling devices, and 3) pain management for 3 of 14 sampled residents (Resident #38, #5, and #18). This deficient practice had the potential to result in residents not receiving the necessary care and services to ensure medications were monitored for the appropriate side effects including increased risk for falls, severe hypotension, constipation, bowel impaction, and complications related to other potential side effects of narcotic and diuretic medications, increased risk for catheter-associated urinary tract infections (CAUTIs), and unrelieved pain. Findings include: Resident #38 Resident #38 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified, urinary tract infection, site not specified, and pressure ulcer of the sacral region, stage III. A Physician Order dated 02/20/2026, documented spironolactone 25 milligram (mg) oral tablet, give one tablet by mouth one time a day for diuretic, hold for a systolic blood pressure less than 90, monitor for signs and symptoms of dehydration. A Physician Order dated 05/20/2026 documented methadone hydrochloride (HCl), give 2.5 mg by mouth three times a day for chronic pain, for 30 days. A Physician Order dated 06/03/2026 documented Dilaudid (hydromorphone) 2 milligram (mg) oral tablets, give 0.5 tablets by mouth every six hours as needed for pain. Resident #38's Comprehensive Care Plan did not include a care plan related to the use and monitoring of methadone, dilaudid and spironolactone. On 06/29/2026 at 12:58 PM, the Minimum Data Set (MDS) Coordinator confirmed Resident #38's Comprehensive Care Plan did not include a care plan related to the use of methadone, dilaudid, or spironolactone. The MDS Coordinator verbalized it was important to have the medications care planned to inform staff the resident needed to be monitored for concerns related to side effects of the medications. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Osteomyelitis of vertebra, sacral and sacrococcygeal region, diabetes mellitus 2 with neuropathy, and stage 4 pressure ulcer to sacrum. On 06/22/2026 at 9:15 AM, Resident #5 had a Foley catheter in place. The drainage bag was secured to the bed frame, and clear yellow urine was in the bag. The resident representative verbalized the resident had a Foley catheter in place. A Minimum Data Set (MDS) admission assessment, completed 03/20/2025, documented Resident #5 had an indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physicians Order dated 03/11/2025, documented Foley catheter 16Fr with 30cc balloon, clean Foley site every day and evening shift for skin impairment management. On 06/24/2026 at 3:23 PM, during a review of Resident #5's care plan, the care plan included a focus area of enhanced barrier precautions related to the catheter. The care plan for Resident #5 lacked a plan for addressing Resident #5's Foley catheter care interventions and goals. A Progress Note dated 03/16/2025, documented Resident #5's catheter was leaking, sterile gloves donned, saline water 5 milliliters (ml) inserted, 18 ml withdrawn, urine return still noted, filled foley balloon per order with 30 ml of saline. On 06/25/2026 at 2:44 PM, the Registered Nurse (RN) verbalized a care plan for a resident with a Foley catheter should include monitoring for signs and symptoms of infection, cleaning of the insertion site, assuring privacy cover was in place over the drainage bag, keeping the drainage bag below the level of the bladder, and changing of the catheter. On 06/25/2026 at 3:34 PM, the acting Director of Nursing (DON) verbalized a care plan for a resident with a Foley catheter should include interventions and goals related to signs and symptoms of infection, cleaning of the insertion site, assuring privacy cover was in place over the drainage bag, keeping the drainage bag below the level of the bladder, and changing of the catheter. The acting DON confirmed a focus area related to the care of the resident's catheter was not on Resident #5's care plan. The Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 RAI User's Manual, version 1.1.9.1, documented the facility was to develop a care plan for each resident which included measurable objectives and timeframes, and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan was to be revised on an ongoing basis to reflect changes in the resident and care the resident was receiving. Resident #18 Resident #18 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, unspecified and major depressive disorder, recurrent, moderate. On 06/22/2026 at 11:09 AM, Resident #18 verbalized pain management was a big issue for the resident. The resident had pain in the resident's back, left leg, and shoulder. For pain control, the resident took oxycodone 30 milligrams every three hours. The pain medication kept the pain at a tolerable level. A Minimum Data Set 3.0 (MDS) assessment dated [DATE], section J, documented Resident #18 had pain almost constantly. The pain, rated at its worst, was a 10 on a 0-10 scale. Resident #18's Care Plan documented the resident had pain which interfered with sleep, rehabilitation activities, and day to day activities. Goals included the resident would voice a level of comfort of (SPECIFY residents states range of comfort) out of (SPECIFY) through the review date. Interventions included the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's pain is aggravated by: (SPECIFY) -The resident's pain is alleviated/relieved by: (SPECIFY) -Monitor/record pain characteristics (SPECIFY FREQ) and PRN: quality, severity, anatomical location, onset, duration, aggravating factors, relieving factors. -The resident is able to: (SPECIFY: call for assistant when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain). On 06/25/2026 at 3:54 PM, the MDS Coordinator verbalized the care plan for residents with pain should include interventions such as assessing objective and subjective manifestations of pain, administering pain medication as prescribed, monitoring for side-effects, and offering non-pharmaceutical pain management interventions. On 06/25/2026 at 4:45 PM, the MDS Coordinator reviewed Resident #18's Care Plan and confirmed the Care Plan related to pain was not resident-specific due to several areas reflecting SPECIFY and not being filled with in the resident's level of comfort, aggravating factors, alleviating factors and frequency of pain monitoring. On 06/25/2026 at 5:02 PM, the MDS Coordinator denied the facility had a policy related to care planning and explained the facility followed the Resident Assessment Instrument 3.0 (RAI) manual. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, updated 10/2025, documented the MDS was to be analyzed and combined with other relevant information to develop and individualized care plan. The care plan was to be revised on an ongoing basis to reflect changes in the resident and the care the resident was receiving.