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	05/01/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 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. Findings include: Resident #45 Resident #45 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy and idiopathic normal pressure hydrocephalus. 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. 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. 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. 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. 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	05/01/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. FRI #NV00073587

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	05/01/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 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. Findings include: Resident #43 Resident #43 was admitted to the facility on [DATE] and readmitted on [DATE], and discharged on [DATE], 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. 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. 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. 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. (continued on next page)

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	05/01/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. A Social Services progress note, dated 03/10/2025, documented the resident could not recall the incident and had no emotional concerns. 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. 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. 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. The facility document titled Resident Rights, undated, documented a resident in the facility would have the right to be treated with respect and dignity. FRI #NV00073619 Cross reference tags F603 and F943

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	05/01/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on clinical record review, interview, and document review the facility failed to ensure a Minimum Data Set 3.0 (MDS) assessment was accurate for 1 of 13 sampled residents (Resident #29). This deficient practice had the potential to deprive residents of necessary care and services relative to current health management needs in the facility. Findings include: Resident #29 Resident #29 was admitted to the facility on [DATE], with a diagnosis of type one diabetes mellitus with diabetic chronic kidney disease. A Physician's Order dated 08/20/2024, documented Eliquis oral tablet 5 milligrams (mg), give 5 mg by mouth two times a day for Deep Vein Thrombosis (DVT) prophylaxis. Resident #29's Medication Administration Record (MAR) for April 2025 documented Eliquis 5 mg was administered to the resident from 04/01/2025 through 04/30/2025. An MDS assessment dated [DATE], Section N - Medications, item E - Anticoagulant lacked an X or any other documentation indicating the resident was taking an anticoagulant medication. On 05/01/2025 at 3:10 PM, the MDS Coordinator explained if a resident was taking any high-risk medications, the medication would be documented in section N of the MDS assessment. The MDS Coordinator confirmed Resident #29 was taking an anticoagulant medication and verbalized the last MDS assessment completed for the resident was dated 04/14/2025. After review of the 04/14/2025 assessment, the MDS Coordinator confirmed the assessment was inaccurate as the assessment did not document the resident was taking an anticoagulant medication. The Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.1.9.1, dated 10/2024, documented medications were an integral part of the care provided to residents of nursing homes. Section N - High-risk drug classes was intended to capture and record the number of days, during the 7 day lookback period, any type of injection, insulin, and/or selected medications were received by the resident. Residents taking high-risk medications were at risk of side effects which could adversely affect health, safety, and quality of life. High-risk drug classes included anticoagulants.

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	05/01/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview, record review and document review, the facility failed to ensure 1) the facility had a process in place to identify and refer residents for pre-admission screening and resident review (PASARR) level II and 2) to initiate a submission for a determination of a Preadmission Screening and Resident Review (PASARR) level I for 1 of 13 sampled residents (Resident 4). The deficient practice had the potential to deprive residents from obtaining appropriate behavioral health services. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with diagnoses including unspecified psychosis not due to a substance or known physiological condition, depression, unspecified, and other symptoms and signs involving cognitive functions and awareness. Resident #4's PASARR Level I documented completion on 04/03/2013. The PASARR Level I documented IC-no Mental Illness, Mental Retardation, or Related Conditions. PASARR appropriate for Nursing Facility (NF) placement. Resident #4's Minimum Data Set (MDS) 3.0 quarterly screening, Section I-Active Diagnoses, dated 02/21/2025, documented the resident had depression and psychotic disorder. Resident #4's facesheet documented the following active diagnoses pronounced after the date of admission to the facility. -Other symptoms and signs involving cognitive functions and awareness. The diagnosis was made on 03/28/2025. -Unspecified psychosis not due to a substance or known physiological condition. The diagnosis was made on 09/17/2024. On 05/01/2025 at 10:32 AM, the Licensed Social Worker (LSW) verbalized the LSW did not have any job responsibilities related to PASARR for the facility and the Admissions Director was responsible for handling PASARR processes. On 05/01/2025 at 10:38 AM, the Admissions Director explained not knowing what a PASARR was but that it was a requirement to have in a residents clinical file prior to admission to the facility. The Admission Director verbalized the Admissions Director had not been trained on proper timeframes for a PASARR Level I when collecting the information upon resident admission to the facility and no formal training had been provided to the Admissions Director. The Admissions Director admitted to having knowledge of no one handling PASARR in the facility and referred the Inspector to the Administrator. (continued on next page)

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	05/01/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/2025 at 10:43 AM, the Administrator confirmed the facility did not have an employee looking at the processes and procedures for PASARRs and verbalized the processes surrounding PASARR Level I and PASARR Level II had been fractured. The Administrator admitted the Social Worker needed to be in charge of handling the PASARR screening process and the process of handling PASARRs was not being done in the facility. The Administrator explained the purpose of a PASARR Level I was to identify mental illness or cognitive issues a resident may have to see if placement in the facility was appropriate. The Administrator admitted not knowing what a PASARR Level II was or what the purpose of initiating a PASARR Level II would do for a resident. On 05/01/2025 at 11:11 AM, the Senior Administrator of Nevada explained all residents were required to have a PASARR Level I prior to admission to the facility to determine if NF placement would be appropriate for a resident and all PASARR Level I should not be older than 6 months prior to admission to the facility. The Senior Administrator of Nevada explained the PASARR Level I needed to contain accurate diagnoses for review to ensure accuracy of placement of a resident. The Senior Administrator of Nevada was not aware if Resident #4 was receiving behavioral health services for the diagnoses of unspecified psychosis or symptoms and signs involving cognitive functions and awareness. On 05/01/2025 at 11:16 AM, the Director of Nursing (DON) verbalized Resident #4 had behaviors such as hallucinations, paranoia, anger, and frustration because the resident was seeing things that were not there. The facility policy titled PASRR Process Policy and Procedure, published 01/09/2025, documented upon admission to the facility, the Admissions Coordinator, Medical Records Director, or designee would validate a PASRR Level I and include it in the admission paperwork. If one was not available, the Admissions Coordinator would contact the hospital to obtain. If a Level II evaluation was needed, the Social Worker would be involved. The Social Services Director would track a residents admitted , PASRR Level I in the chart, ensure a positive PASRR I had a referral for evaluation, date the Level II was placed in the resident's chart, date and 'invalidation' was placed in the resident's chart, and follow up as needed per Federal PASRR rules.

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	05/01/2025

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 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** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure Oxygen use and associated diagnoses were care planned for 1 of 13 sampled residents (Resident #34). This deficient practice had the potential to result in staff working with the resident to be unaware of the need to monitor the resident for shortness of breath or difficulty breathing, provide Oxygen as ordered, and monitor Oxygen saturation. Findings include: Resident #34 Resident #34 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and chronic systolic (congestive) heart failure. On 04/28/2025 at 9:45 AM, Resident #34 was receiving Oxygen via a Nasal Cannula (NC). The resident's Oxygen concentrator was set at 2.5 liters per minute (LPM). On 05/01/2025 at 7:49 AM, Resident #34 was sitting on the edge of the resident's bed. A NC was hanging below the resident's chin. A Registered Nurse (RN) entered Resident #34's room and adjusted the resident's NC. The RN explained Resident #34 was supposed to be on two liters of Oxygen. The RN checked Resident #34's Oxygen concentrator, verbalized the concentrator was set to three liters per minute, and explained Resident #34 often removed the NC at night and staff had to increase the amount of Oxygen being administered. A Physician's Order dated 02/26/2025, documented Oxygen 2 LPM. Delivery: cannula, mask. Continuous. Resident #34's Care Plan lacked documentation related to use of Oxygen and the resident's diagnoses of chronic obstructive pulmonary disease, congestive heart failure and asthma. On 05/01/2025 at 1:58 PM, the Director of Nursing (DON) confirmed a resident's use of Oxygen should be included on the resident's Care Plan. The DON explained the facility created resident care plans by body system and any disease processes the resident had. The DON confirmed Resident #34 had a current physician order for Oxygen administration. The DON verbalized the DON would have to review the Care Plan to confirm if the Oxygen and associated diagnosis were included. On 05/01/2025 at 4:22 PM, the DON verbalized Resident #34's Care Plan had been updated to include the diagnosis of congestive heart failure, use of Oxygen, and need for Oxygen saturation monitoring. The DON explained the DON reviewed Resident #34's clinical record prior to updating the Care Plan and confirmed the Care Plan lacked a problem, goals, or interventions related to congestive heart failure or the resident's use of Oxygen. (continued on next page)

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	05/01/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, dated 10/2024, 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. Cross reference tag F695

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	05/01/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on observation, interview, record review and document review, the facility failed to ensure a resident who relied on staff for Activities of Daily Living (ADLs) received scheduled showers or baths as required for 1 of 13 sampled residents (Resident #19). The deficient practice had the potential to increase skin breakdown, infections, odor, and bacteria buildup. Findings include: Resident #19 Resident #19 was admitted on [DATE] and readmitted on [DATE] with diagnoses including intervertebral disc degeneration, lumbar region with discogenic back pain, muscle weakness, and atrial fibrillation. On 04/28/2025 at 12:54 PM, Resident #19 verbalized not receiving showers regularly as scheduled and gave their own bed bath. The resident explained feeling itchy and bad about themselves when not receiving regular scheduled showers. The Minimum Data Set (MDS) 3.0 in section GG dated 02/13/2025, indicated substantial/maximal assistance with showering and bathing self. Resident #19's Care Plan initiated on 04/17/2025, indicated resident required substantial/max assist by one staff for ADL care related to bathing/showering. Resident #19's medical record for February, March and April 2025 lacked documented evidence the resident received either a shower, bath or bed bath twice a week as scheduled on the following dates: -02/13/2025 -02/17/2025 -02/27/2025 -03/13/2025 -03/17/2025 -03/20/2025 -03/24/2025 -03/27/2025 -03/31/2025 (continued on next page)

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	05/01/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/03/2025 -04/07/2025 -04/14/2025 -04/18/2025 -04/21/2025 -04/28/2025 Resident #19's medical record lacked documented evidence the resident refused a shower or bath during the above-mentioned dates, and shower or bath were not provided on other days to compensate for the missed shower or bath as scheduled. On 04/30/2025 at 10:47 AM, a nurse apprentice explained showers were provided to residents twice a week depending on the shower schedule for each resident. Skin Observation and Shower sheets were utilized to document if a shower or bath was provided to the resident. If the shower or bath was denied by the resident, the staff would document the refusal on the Skin Observation and Shower sheet and turned into the Infection Preventionist. Another means of documenting the shower or bath was in the electronic health record (EHR). On 04/30/2025 at 11:00 AM, an observation of the shower schedule was posted at the nursing station, indicated showers were designated twice a week for Resident #19 (room [ROOM NUMBER]), which were Mondays and Fridays. On 05/01/2025 at 2:41 PM, the Director of Nursing (DON) explained the Certified Nursing Assistant (CNA) was to report to the on-shift nurse if the resident refused showers. The CNA was to document the shower on the Skin Observation and Shower sheet and in the EHR. Resident #19's documented showers from February to April were reviewed with the DON. The DON confirmed there was no documented evidence the resident was offered a shower or bath on 02/13/2025, 02/17/2025, 02/27/2025, 03/13/2025, 03/17/2025, 03/20/2025, 03/24/2025, 03/27/2025, 03/31/2025, 04/03/2025, 04/07/2025, 04/14/2025, 04/18/2025, 04/21/2025, and 04/28/2025. The DON confirmed the findings and indicated there was no documentation Resident #19 had refused or was unavailable during the shift.

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	05/01/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure 1 of 13 sampled residents (Resident #27) received appropriate care to prevent a urinary tract infection (UTI) when facility policy and Centers for Disease Control and Prevention (CDC) recommendations related to Transmission-Based Precautions (TBP) were not followed and the resident remained in a shared room with another resident known to have an active infection with a Multidrug-Resistant Organism (MDRO). This deficient practice resulted in potentially avoidable isolation of the resident, UTI with an MDRO, and treatment with Intravenous (IV) antibiotics (ABX). Findings include: Resident #32 Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia and chronic kidney disease, stage four (severe). On 04/28/2025 at 7:31 AM, a sign was attached to the door frame of Resident #32 and Resident #27's room. The sign indicated the room had contact precautions in place, requiring a gown and gloves be donned prior to entering the room. A Personal Protective Equipment (PPE) cart was in the hall outside the room. The cart contained gowns, gloves, surgical masks and N95 masks. On 04/28/2025 at 7:47 AM, a Licensed Practical Nurse (LPN) assigned to care for Resident #32 and Resident #27 verbalized the contact precautions were in place due to Extended-Spectrum Beta-Lactamase (ESBL) in the resident's urine. The LPN confirmed two residents were staying in the room and verbalized both residents were on contact precautions. The following were included in Resident #32's clinical record: A Results Report for a urinalysis, complete with reflex to culture. The collection date was 02/12/2025, and the reported date was 02/17/2025. The report documented a urine culture result of greater than 100,000 CFU/ ml of E. coli. The therapy comments section of the report documented the organism was confirmed as an ESBL producer. Orders-Administration Notes dated 02/20/2025 and 02/21/2025, documented Ertapenem Sodium solution reconstituted, one gram IV every 24 hours for UTI for ten days. Awaiting peripherally inserted central catheter line placement. A Daily Skilled Note dated 02/28/2025, documented Resident #32 had a right arm midline. Resident on regimen of Ertapenem x 4 days to be completed 03/01/2025, no adverse reaction noted. (continued on next page)

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	05/01/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	On 04/29/2025 at 3:22 PM, the Infection Preventionist (IP) verbalized an MDRO was a multidrug-resistant organism. Residents were at high risk for contracting an MDRO if an ABX was inappropriately prescribed, when a catheter was inserted when not necessary or without using sterile technique, and when there was a lack of appropriate PPE. TBP included contact, droplet, and airborne precautions. The IP explained the intent of TBP was to protect the resident and keep residents from transmitting organisms to other residents. On 04/29/2025 at 3:33 PM, during an interview with the Director of Nursing (DON) and the IP, the DON and IP explained residents requiring TBP included residents infected with MDROs. Nursing was allowed to implement TBP, following the facility's policy for infection control and per CDC guidelines. If a resident was on contact precautions, the resident may be allowed to have a roommate if the roommate had the same organism. The IP and DON confirmed TBP were in place for Resident #27 on 04/28/2025. The DON confirmed Resident #27 had a roommate, Resident #32, and verbalized the residents had shared a room for a long time. On 04/30/2025 at 2:27 PM, during an interview with the DON, the IP, and the Regional Director of Clinical Operations (RDCO), the DON explained the indication for placing Resident #27 on TBP was ESBL E. coli in the resident's urine. The DON confirmed Resident #32 had been infected with the same organism. The IP verbalized Resident #32 was positive for ESBL E. coli per the results of a urine culture collected on 02/12/2025. Resident #32 was sent to the hospital not long after the collection of the urine specimen, returned to the facility on [DATE], and was placed on contact precautions. The DON denied Resident #32 was placed in a private room upon return to the facility and explained the resident was placed in a shared room with Resident #27. The DON and IP reviewed Resident #32's urine culture result report dated 02/17/2025. The DON confirmed the therapy comments section at the bottom of the report documented the organism was confirmed as an ESBL producer. The IP acknowledged the report indicated the organism was resistant to multiple drugs. The IP confirmed Resident #32 should have been placed in a private room upon return to the facility on [DATE]. Resident #27 Resident #27 was admitted to the facility on [DATE], with diagnoses including spastic hemiplegia affecting right dominant side, bipolar II disorder, major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified, and post-traumatic stress disorder, chronic. On 04/28/2025 at 2:53 PM, Resident #27 verbalized the resident was on isolation precautions related to a UTI. The resident was taking ABX to treat the UTI and complained of nausea and vomiting since starting the ABX. Resident #27 became tearful during interview and verbalized the resident had been in isolation for approximately one month. The resident explained the resident had really bad anxiety and the isolation made the anxiety worse. (continued on next page)

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	05/01/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	On 04/28/2025 at approximately 3:30 PM, a Certified Nursing Assistant (CNA) was preparing to enter Resident #27's room. The CNA affirmed the CNA was assigned to provide care to both Resident #27 and Resident #32 during the shift. The following were included in Resident #27's clinical record: A Progress Note dated 03/19/2025 documented Resident #27 complained of dysuria and frequency. Nurse spoke to the physician and obtained an order for a urinalysis (UA). A Lab Results Report, with a collection date of 03/19/2025 and a reported date of 03/24/2025, documented a urine culture result of greater than 100,000 Colony Forming Units (CFU)/ milliliter (ml) of ESBL producing Escherichia coli (E. coli). The organism showed resistance to the following: Ampicillin, Ampicillin/Sulbactam, Cefazolin, Cefepime, Ceftazidime, Ceftriaxone, Cefuroxime, Ciprofloxacin, Gentamicin, Levofloxacin, Nitrofurantoin, Tobramycin, and Trimethoprim/Sulfamethoxazole. An Orders-Administration Note dated 03/24/2025, documented Ceftolozane-Tazobactam IV solution reconstituted 1.5 (1-0.5) grams (GM). Use 1.5 GM IV every eight hours for E. coli/ ESBL UTI. A Nursing Progress Note dated 03/25/2025, documented new order obtained for Meropenem 500 milligrams (mg) IV every eight hours for UTI. New order for Normal Saline (NS) one liter for rehydration. 22 gauge to left wrist started, no complaints of pain, no signs or symptoms of infiltration. NS infusing, will continue to monitor. An Orders-Administration Note dated 04/04/2025, documented resident to be in isolation due to ESBL in urine. Meals to be given on disposable trays. All care provided by staff to be done in room. Resident to be in private room with no roommate. Every day and night shift for isolation precautions. A Physician's Order dated 04/14/2025, documented Linezolid oral tablet 600 mg, give one tablet by mouth two times a day for UTI for 14 days. A Physician's Order dated 04/17/2025, documented contact precautions for enterococcus faecalis in urine. Every day and night shift until 05/01/2025. End contact isolation 72 hours after ABX regimen is complete. A Daily Census Report dated 02/24/2025, documented there were 18 empty beds in the facility. The facility's Monthly Line Listing of infections for February 2025, documented Resident #32 had a UTI. The date of infection was listed as 02/13/2025. The pathogen/organism was E. coli ESBL, the infection was healthcare associated, and contact precautions were initiated. Resident #32's clinical record documented on 02/13/2025, the resident was sharing a room with Resident #27. The facility's Monthly Line Listing of infections for March 2025, documented Resident #27 had a UTI. The date of infection was listed as 03/25/2025. The pathogen/organism was E. coli, the infection was healthcare associated, and contact precautions were initiated. The facility's CNA and nurse schedule for March 2025 documented one nurse worked in the facility during the night shift on 03/01/2025 through 03/05/2025. (continued on next page)

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	05/01/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	On 04/29/2025 at 4:32 PM, the DON explained an adequate number of staff to care for residents in the facility varied by acuity. At a minimum, the facility would staff one nurse and three CNAs at night. The DON confirmed the facility had shifts when only one nurse was in the facility to provide nursing care to all residents. On 04/30/2025 at 2:27 PM, the IP explained the first time the facility was aware of and had documentation of Resident #27 testing positive for ESBL E. coli was 03/25/2025, after sharing a room with Resident #32. The facility policy titled Transmission Based Precautions, published 01/2025, documented it was the policy of the facility to implement Transmission-Based Precautions (TBP) for residents known to be, or suspected of being, infected with infectious agents. The four types of TBP included contact, droplet, airborne, and enhanced barrier precautions. The need to implement TBP was determined by the IP, DON, and/or consultation with the local health department. Precautions were based on CDC guidelines. Contact, or touch, was the most common and most significant mode of transmission of infectious agents. Contact transmission could occur by directly touching the resident, through contact with the resident's environment, or by using contaminated gloves or equipment. Options for residents on contact precautions could include a private room, cohorting with another infected or colonized resident or sharing a room with a resident with limited risk factors. The CDC document titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated 09/2024, documented MDROs were generally defined as microorganisms which were resistant to one or more classes of antimicrobial agents. MDROs of concern included those producing ESBL. Documented outbreaks in long-term care facilities were caused by various viruses and bacteria and could lead to substantial morbidity and mortality and increased medical costs. Prompt detection and implementation of effective control measures were required. Placement of a resident in a single room was preferred when there was concern about transmission of an infectious agent, including residents on contact and droplet precautions. Recommendations for residents infected or colonized with an MDRO judged as clinically important by the infection control program included contact in addition to standard precautions. Cross reference tag F880.

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	05/01/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure oxygen was administered according to a physician's order for 1 of 13 sampled residents (Resident #34). This deficient practice had the potential to cause worsening of the resident's diagnosed chronic obstructive pulmonary disease. Findings include: Resident #34 Resident #34 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and chronic systolic (congestive) heart failure. On 04/28/2025 at 9:45 AM, Resident #34 was receiving Oxygen via a Nasal Cannula (NC). The resident's Oxygen concentrator was set at 2.5 liters per minute (LPM). On 05/01/2025 at 7:49 AM, Resident #34 was sitting on the edge of the resident's bed. A NC was hanging below the resident's chin. A Registered Nurse (RN) entered Resident #34's room and adjusted the resident's NC. The RN explained Resident #34 was supposed to be on two liters of Oxygen. The RN checked Resident #34's Oxygen concentrator, verbalized the concentrator was set to three liters per minute. Resident #34 often removed the NC at night and staff had to increase the amount of Oxygen being administered. A Physician's Order dated 02/26/2025, documented Oxygen 2 LPM. Delivery: cannula, mask. Continuous. On 05/01/2025 at 1:58 PM, the Director of Nursing (DON) explained the facility's process for administration of Oxygen included first obtaining an order, checking oxygen saturation, and obtaining an oxygen concentrator. The order would include the LPM to be administered, delivery with a mask or NC, and if necessary, titration of LPM up or down to maintain Oxygen saturation at or above a specific level. The DON reviewed Resident #34's clinical record and confirmed the physician order for Oxygen documented the resident was to receive Oxygen at two LPM. The DON denied it would be appropriate for staff to increase the liter flow to three LPM without obtaining a new order from the physician. On 05/01/2025 at 4:22 PM, the DON verbalized the DON updated Resident #34's Oxygen order. The DON verbalized the DON reviewed Resident #34's clinical record prior to updating the order and confirmed the clinical record lacked an order to increase the LPM or to titrate the LPM based on oxygen saturation readings. (continued on next page)

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	05/01/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration - General Guidelines, reviewed 01/2025, documented medications were to be administered in accordance with written orders of the prescriber. If a dose seemed excessive considering the resident's age and condition, or an order seemed unrelated to the resident's current diagnosis or condition, the nurse was to call the pharmacy or prescriber as necessary for clarification. The interaction with the pharmacy and the resulting order clarification were to be documented in the nursing notes and elsewhere in the record as appropriate. Cross reference tag F656

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	05/01/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 31739 Based on personnel record review and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) employed greater than one year had a performance review completed annually for 1 of 3 CNAs reviewed for completed performance review. This deficient practice had the potential to affect all residents when the facility did not identify areas of CNA performance in need of insevice education/training. Findings include: Employee #9 Employee #9 was hired on 08/31/2023 as a CNA. Employee #9's personnel record lacked documentation a performance review had been completed in 2024. On 04/30/2025 at 11:45 AM, the Director of Nursing verbalized having been responsible for completing CNA performance evaluations and confirmed Employee #9 had not received a performance review upon the employee's one year anniversary. The facility policy titled, Nursing Personnel Education and Training, published 11/2016, documented employee reviews were to be completed every 12 months and identify areas of improvement and competencies to be completed as needed.

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	05/01/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure medications were administered with an error rate of less than five percent (%). There were 26 opportunities observed and two errors. The medication error rate was 7.69%. Findings include: Resident #38 Resident #38 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery, intracardiac thrombosis, not elsewhere classified, and ventricular tachycardia, unspecified. On 04/30/2025 at 8:14 AM, a Registered Nurse (RN)1 began preparing medications for Resident #38. The RN1 verbalized some of the resident's ordered medications were out of stock in the medication cart and the RN1 would need to go to the medication storage room to see if there was additional stock of the medications available. On 04/30/2025 at 8:18 AM, while in the medication storage room, the RN1 accessed an automated medication dispensing system, managed by the contracted pharmacy. The RN1 verbalized there were no doses of Pradaxa available, and the RN1 would need to call the pharmacy. On 04/30/2025 at 8:30 AM, the RN1 administered medications to Resident #38. The medications administered did not include Pradaxa. A Physician's Order dated Pradaxa oral capsule 150 milligrams (mg), give 150 mg capsule by mouth one time a day for thrombus treatment. The order date was 02/25/2025. Resident #38's Medication Administration Record (MAR) documented the 04/30/2025 dose of Pradaxa 150 mg was not administered and indicated the medication was OO. The MAR key documented OO equated to On Order from Pharmacy. Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including obstructive and reflux uropathy, unspecified and encounter for surgical aftercare following surgery on the genitourinary system. On 05/01/2025 at 7:40 AM, an RN2 began preparing medications for Resident #15. The RN2 verbalized the resident's physician ordered Finasteride was not in the medication cart, the RN would reorder the medication in the electronic medical record, and would have to call the pharmacy. On 05/01/2025 at 7:44 AM, the RN2 administered medications to Resident #15. The medications administered did not include Finasteride. (continued on next page)

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	05/01/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15's MAR documented Finasteride oral tablet 5 mg, give 5 mg by mouth one time a day for benign enlargement of prostate. Wear gloves when handling. The order start date was 02/27/2025. The MAR documented the 05/01/2025 dose of Finasteride 5 mg was not administered and indicated the medication was OO. The MAR key documented OO equated to On Order from Pharmacy. On 05/01/2025 at 11:17 AM, the Regional Director of Clinical Operations (RDCO) verbalized facility did not have a policy related to medication administration errors. On 05/01/2025 at 2:25 PM, the Director of Nursing (DON) explained the DON's expectation of nursing staff when administering medications to residents was the follow the rights of medication administration. Rights of medication administration included the right resident, right dose, right medication, and the right route. Additionally, nurses were expected to check each medication prior to administration, assure the right medication had been delivered from the pharmacy, assess pain or vital signs as necessary, and use alcohol-based hand sanitizer when entering and exiting a resident's room. Medication administration errors included administering the wrong medication, missing a medication for an unexplained reason, and not administering the medication at the scheduled time. The DON explained if a medication was not onsite to administer to a resident, the nurse was to check the automated medication dispensing system and call the pharmacy. If a medication was on order from the pharmacy, the nurse should notify the physician. The physician could give an order to administer the medication when it arrived from the pharmacy if the medication was going to be delivered the same day. The DON verbalized the DON would have to look up if failing to administer a physician ordered medication and the absence of documentation of contact with the pharmacy and notification of the physician would be considered a medication error. On 05/01/2025 at 2:25 PM, the DON verbalized the DON would review Resident #38 and #15's clinical records related to the medications marked OO during the 04/30/2025 and 05/01/2025 AM medication pass. On 05/01/2025 at 5:05 PM, the DON verbalized the DON was not able to provide documentation of notification of the physician, orders for alternate medications, or orders allowing staff to administer the medications late for Resident #38 and #15. The DON verbalized the DON had explained to the nurse there needed to be documentation of contact with both the physician and the pharmacy when a medication was not available to administer at the scheduled time. The facility policy titled Medication Administration General Guidelines, reviewed 01/2025, documented medications were to be administered as prescribed and in accordance with manufacturer's specifications, good nursing principles and practices. Prior to administration, staff were to review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Medications were to be administered within 60 minutes of scheduled time, except before or after meal orders, which were to be administered based on mealtimes. If a dose of regularly scheduled medication was withheld, refused, or given at other than the scheduled time, the nurse shall document the dose was withheld, refused, or given at other than scheduled time, and enter an explanatory note. (continued on next page)

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	05/01/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Davis's Drug Guide for Nurses, 12th edition, documented incorrect drug administration covered many problems. Misidentification of a patient, incorrect route of administration, missed doses, or improper drug preparation were types of errors which could occur during the administration phase.

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	05/01/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, and document review the facility failed to ensure a multi-dose vial was labeled with the date the vial was opened in 1 of 1 medication storage rooms inspected. This deficient practice placed residents at risk for injection with expired Tuberculin Purified Protein Derivative (PPD) solution and potentially inaccurate Tuberculin PPD skin test results. Findings include: On [DATE] at 3:39 PM, during an inspection of the medication storage room and in the presence of the Infection Preventionist (IP), a vial of Tuberculin PPD (Mantoux) 5 Tuberculin Units (TU)/ 0.1 milliliters (ml) was found in the medication storage refrigerator. The vial lacked a cap, and a puncture site was observed in the rubber stopper. The vial and the manufacturer box lacked an open date. The manufacturer box included instructions to discard the vial within 30 days of opening. The IP confirmed the vial of Tuberculin PPD solution was open and lacked an open date written on the vial and the box. The IP verbalized the vial would need to be destroyed due to the lack of an open date. The facility policy titled Medication Administration Injectable Vials and Ampules, reviewed ,d+[DATE], documented the date opened and initials of the first person to use the vial were to be recorded on multi-dose vials.

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	05/01/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 30748 Based on interview and document review, the facility failed to ensure the Facility Assessment (FA) was reviewed, updated, included input from and was approved by facility leadership and management Quality Assessment and Assurance (QAA) Committee. The deficient practice could result in the facility not being able to determine what resources were necessary to care for its residents competently. Findings include: On 04/30/2025, a review of the FA presented by the Interim Executive Director (IED), dated 03/25/2025, lacked documented evidence of an attendance sheet indicating a review of the FA contents by facility QAA Committee. The previous FA was requested from the IED. However, the FA documented individuals involved in completing the FA, to include the following: -Administrator -Director of Nursing (DON) -Governing Body Representative -Medical Director -Direct Care Representative -Resident Representative. On 04/30/2025 at 8:40 AM, the IED presented the previous FA, dated 08/29/2024. The IED verbalized the previous FA was placed in the shred pile and had to be located by staff. The FA dated 08/29/2024, documented an attendance sheet for review of the FA. The attendance sheet documented the following attendees: -Admissions -The Center Finance Manager -The Housekeeping Manager -The Director of Rehabilitation/Physical Therapist -Minimum Data Set -Activity Director (continued on next page)

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	05/01/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Director of Nursing Services -Maintenance -Resident Council President -Medical Director On 04/30/2025 at 9:39 AM, the IED explained the facility followed the FA dated 03/25/2025, and the FA dated 08/29/2024, was null and void. The IED verbalized there was not an attendance sheet documenting review of the FA dated 03/25/2025, and confirmed the required members of facility leadership and management were not a part of the revision and implementation of the 03/25/2025 FA. The IED confirmed there was no review from the QAA Committee related to the 03/25/2025 FA and the IED was the only one who created the 03/25/2025 FA and implemented the FA. The IED admitted the FA completed on 03/25/2025 was not a valid FA based on the federal regulations and requirements. The facility did not have a policy and procedure related to reviewing, updating, or implementing the FA and the required members who were to attend.

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	05/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure 1) As Needed (PRN) medications were documented timely for 1 of 6 residents observed for medication administration (Resident #7) and 2) a wound care order was entered into the Electronic Medical Record (EMR) for 1 of 13 sampled residents (Resident #12). This deficient practice had the potential for duplicate administration of PRN medications, accurate Medication Administration Records (MARs) to not be available for review during a change in condition or required transfer to the hospital, and for staff providing care to a resident to not be aware of physician ordered care. Findings include: Resident #7 Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including emphysema, unspecified and cervicalgia. On 05/01/2025 at 8:14 AM, during the AM medication administration pass, a Registered Nurse (RN) began preparing medication for Resident #7. The RN verbalized the resident complained of back pain and rated the pain a five out of ten. On 05/01/2025 at 8:18 AM, the RN administered two tablets of Acetaminophen 325 milligrams (mg) to Resident #7. A Physician's Order dated 12/18/2024, documented Acetaminophen oral tablet, give 650 mg by mouth every six hours as needed for pain. Not To Exceed (NTE) three grams per day. On 05/01/2025 at 10:40 AM, Resident #7's MAR lacked documentation of the administration of Acetaminophen. The RN confirmed the RN administered two tablets of Acetaminophen 325 mg to Resident #7 during the AM medication pass. The RN reviewed the resident's MAR and confirmed the MAR lacked documentation of the PRN administration. The RN explained it was important to document the administration of PRN medications at the time of administration because residents could only receive a certain number of doses and there were a specified number of hours required between each dose. On 05/01/2025 at 2:25 PM, the Director of Nursing (DON) verbalized when medications were administered to a resident, it was the DON's expectation the administration be documented in the resident's MAR within 15 minutes of the resident taking the medication. The DON explained timely documentation of medication administration was important for accuracy and resident safety. If a resident had to be sent to the hospital it was necessary to have an accurate MAR to send with the resident. (continued on next page)

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	05/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration General Guidelines, reviewed 01/2025, documented the individual who administered the medication dose was to record the administration on the resident's MAR immediately following the medicating being given. If a PRN medication was administered, the following documentation was to be provided: date and time of administration, dose, complaints or symptoms for which the medication was given, results achieved from giving the dose and the time the results were noted, and the signature or initials of the person recording the administration/results. Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including primary generalized osteoarthritis and type two diabetes mellitus with other circulatory complications. On 04/28/2025 at 7:54 AM, Resident #12 was lying in bed. The resident's head was wrapped with a gauze bandage. On 04/28/2025 at 11:15 AM, the Director of Nursing identified the facility's Infection Preventionist (IP) by name. A Staff List provided by the facility identified the IP as a Resident Care Manager (RCM)/Registered Nurse. On 04/28/2025 at 2:29 PM, the IP and a Licensed Practical Nurse (LPN) were in Resident #12's room. A Nursing Progress Note dated 04/28/2025 at 1:01 AM, documented Resident #12 returned from the emergency room with a negative Computed Tomography (CT) scan. The resident had a dressing on the resident's head for a cranial abrasion. Staff would keep the dressing on until morning. Staff would keep the wound clean and dry until healed. A Nursing Progress Note dated 04/28/2025 at 5:28 PM, documented an LPN and the RCM went into Resident #12's room and evaluated the resident's head injury, an abrasion on the top of the resident's head. The LPN cleansed the resident's hair with soap and water, cleansed the abrasion with wound cleanser and patted dry. The RCM applied Xeroform (a sterile, non-adherent wound dressing impregnated with petrolatum blend) and wrapped the resident's head. Resident #12's clinical record lacked an order for wound care related to the abrasion on Resident #12's head. On 05/01/2025 at 5:00 PM, the IP explained the IP performed weekly evaluations on all wounds in the facility and floor nurses performed dressing changes in between the evaluations. If any new skin impairments were identified, the floor nurse would notify the IP, and the IP would complete an evaluation. The IP confirmed staff were required to obtain an order from the physician prior to performing wound care. (continued on next page)

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	05/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP confirmed the IP was familiar with Resident #12. The IP verbalized the resident had an abrasion on the resident's head resulting from a fall. The IP verbalized the IP had cleansed the abrasion and during an observation the following day, the abrasion was gone. The IP reviewed the Nursing Progress Note dated 04/28/2025 at 5:28 PM, and confirmed the IP had applied Xeroform to the resident's head. The IP explained the IP had spoken to and received approval from the physician prior to performing the wound care however the IP had forgotten to document the order in the resident's record. The facility policy titled Skin Integrity, updated 01/2025, documented for skin impairment identified with admission (included but was not limited to abrasions, bruises, burns) the licensed nurse was to notify the physician, obtain a treatment order (if needed), and document on the Treatment Administration Record (TAR) after the order was implemented. If skin impairment was identified after admission, the licensed nurse was to complete all steps required for impairments identified upon admission in addition to implementation of new interventions, notifying and documenting the notification to physician and resident/representative, and initiating alert charting.

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	05/01/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46301 Based on interview, record review and document review, the facility failed to develop and implement at least one Performance Improvement Project (PIP) per year. This deficient practice had the potential to adversely impact each resident's well-being. Findings include: On 05/01/2025 at 5:12 PM, the Interim Executive Director (IED), Director of Nursing (DON) and the Lead Administrator of Nevada (LAN) revealed Quality Assurance Performance Improvement (QAPI) committee meetings were held monthly and usual attendees included the Administrator, the Medical Director, and the DON. On 05/01/2025 at 5:15 PM, the LAN explained the facility was unable to furnish documentation or describe a PIP completed within the past year due to the facility using an electronic system to document the PIP and after the former Administrator left, the Quality Assurance (QAA) committee, no longer had access. The IED was unsure and was not able to confirm if the facility had any current PIPs and was not able to provide documentation for one. The IED stated having been the Administrator at this facility for a short time and was not able to find where the electronic documents were filed or if they were filed. The IED confirmed the QAPI committee had not been made aware of the facility's failure to follow facility policy, federal, and state law related to reporting of allegations of abuse, neglect, mistreatment, misappropriation of property and exploitation to determine if additional action was necessary. The Quality Assurance/Process Improvement (QAPI) Plan, dated 03/2024, documented QAPI committee meetings would be held monthly. Performance Improvement Projects (PIPs) were evaluated ongoing for effectiveness by the Quality Assurance (QAA) Committee. The QAA committee oversees the Center QAPI program and were tasked with identifying areas requiring performance improvement, collective data, developing and implementing corrective action and creating monitors to determine and validate changes were effective and sustained.

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review, the facility failed to ensure Transmission-Based Precautions (TBP) were implemented according to facility policy and Centers for Disease Control and Prevention (CDC) recommendations for 1 of 13 sampled residents (Resident #27) and Enhanced-Barrier Precautions (EBP) were implemented for 3 of 5 residents meeting criteria for EBP (Resident #20, #6, and #15). This deficient practice had the potential to increase risk of spreading infectious organisms throughout the facility. Findings include: Transmission-Based Precautions Resident #32 Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia and chronic kidney disease, stage four (severe). On 04/28/2025 at 7:31 AM, a sign was attached to the door frame of Resident #32 and Resident #27's room. The sign indicated the room had contact precautions in place, requiring a gown and gloves be donned prior to entering the room. A Personal Protective Equipment (PPE) cart was in the hall outside the room. The cart contained gowns, gloves, surgical masks and N95 masks. On 04/28/2025 at 7:47 AM, a Licensed Practical Nurse (LPN) assigned to care for Resident #32 and Resident #27 verbalized the contact precautions were in place due to Extended-Spectrum Beta-Lactamase (ESBL) in the resident's urine. The LPN confirmed two residents were staying in the room and verbalized both residents were on contact precautions. The following were included in Resident #32's clinical record: A Results Report for a urinalysis, complete with reflex to culture. The collection date was 02/12/2025, and the reported date was 02/17/2025. The report documented a urine culture result of greater than 100,000 CFU/ ml of E. coli. The therapy comments section of the report documented the organism was confirmed as an ESBL producer. Orders-Administration Notes dated 02/20/2025 and 02/21/2025, documented Ertapenem Sodium solution reconstituted, one gram IV every 24 hours for UTI for ten days. Awaiting peripherally inserted central catheter line placement. A Daily Skilled Note dated 02/28/2025, documented Resident #32 had a right arm midline. Resident on regimen of Ertapenem x4 days to be completed 03/01/2025, no adverse reaction noted. (continued on next page)

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/29/2025 at 3:22 PM, the Infection Preventionist (IP) verbalized an MDRO was a multidrug-resistant organism. Residents were at high risk for contracting an MDRO if an ABX was inappropriately prescribed, when a catheter was inserted when not necessary or without using sterile technique, and when there was a lack of appropriate PPE. TBP included contact, droplet, and airborne precautions. The IP explained the intent of TBP was to protect the resident and keep residents from transmitting organisms to other residents. On 04/29/2025 at 3:33 PM, during an interview with the Director of Nursing (DON) and the IP, the DON and IP explained residents requiring TBP included residents infected with MDROs. Nursing was allowed to implement TBP, following the facility's policy for infection control and per CDC guidelines. If a resident was on contact precautions, the resident may be allowed to have a roommate if the roommate had the same organism. The IP and DON confirmed TBP were in place for Resident #27 on 04/28/2025. The DON confirmed Resident #27 had a roommate, Resident #32, and verbalized the residents had shared a room for a long time. On 04/30/2025 at 2:27 PM, during an interview with the DON, the IP, and the Regional Director of Clinical Operations (RDCO), the DON explained the indication for placing Resident #27 on TBP was ESBL E. coli in the resident's urine. The DON confirmed Resident #32 had been infected with the same organism. The IP verbalized Resident #32 was positive for ESBL E. coli per the results of a urine culture collected on 02/12/2025. Resident #32 was sent to the hospital not long after the collection of the urine specimen, returned to the facility on [DATE], and was placed on contact precautions. The DON denied Resident #32 was placed in a private room upon return to the facility and explained the resident was placed in a shared room with Resident #27. The DON and IP reviewed Resident #32's urine culture result report dated 02/17/2025. The DON confirmed the therapy comments section at the bottom of the report documented the organism was confirmed as an ESBL producer. The IP acknowledged the report indicated the organism was resistant to multiple drugs. The IP confirmed Resident #32 should have been placed in a private room upon return to the facility on [DATE]. Resident #27 Resident #27 was admitted to the facility on [DATE], with diagnoses including spastic hemiplegia affecting right dominant side, bipolar II disorder, major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified, and post-traumatic stress disorder, chronic. On 04/28/2025 at 2:53 PM, Resident #27 verbalized the resident was on isolation precautions related to a UTI. The resident was taking ABX to treat the UTI and complained of nausea and vomiting since starting the ABX. Resident #27 became tearful during interview and verbalized the resident had been in isolation for approximately one month. The resident explained the resident had really bad anxiety and the isolation made the anxiety worse. (continued on next page)

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/2025 at approximately 3:30 PM, a Certified Nursing Assistant (CNA) was preparing to enter Resident #27's room. The CNA affirmed the CNA was assigned to provide care to both Resident #27 and Resident #32 during the shift. The following were included in Resident #27's clinical record: A Progress Note dated 03/19/2025 documented Resident #27 complained of dysuria and frequency. Nurse spoke to the physician and obtained an order for a urinalysis (UA). A Lab Results Report, with a collection date of 03/19/2025 and a reported date of 03/24/2025, documented a urine culture result of greater than 100,000 Colony Forming Units (CFU)/ milliliter (ml) of ESBL producing Escherichia coli (E. coli). The organism showed resistance to the following: Ampicillin, Ampicillin/Sulbactam, Cefazolin, Cefepime, Ceftazidime, Ceftriaxone, Cefuroxime, Ciprofloxacin, Gentamicin, Levofloxacin, Nitrofurantoin, Tobramycin, and Trimethoprim/Sulfamethoxazole. An Orders-Administration Note dated 03/24/2025, documented Ceftolozane-Tazobactam IV solution reconstituted 1.5 (1-0.5) grams (GM). Use 1.5 GM IV every eight hours for E. coli/ ESBL UTI. A Nursing Progress Note dated 03/25/2025, documented new order obtained for Meropenem 500 milligrams (mg) IV every eight hours for UTI. New order for Normal Saline (NS) one liter for rehydration. 22 gauge to left wrist started, no complaints of pain, no signs or symptoms of infiltration. NS infusing, will continue to monitor. An Orders-Administration Note dated 04/04/2025, documented resident to be in isolation due to ESBL in urine. Meals to be given on disposable trays. All care provided by staff to be done in room. Resident to be in private room with no roommate. Every day and night shift for isolation precautions. A Physician's Order dated 04/14/2025, documented Linezolid oral tablet 600 mg, give one tablet by mouth two times a day for UTI for 14 days. A Physician's Order dated 04/17/2025, documented contact precautions for enterococcus faecalis in urine. Every day and night shift until 05/01/2025. End contact isolation 72 hours after ABX regimen is complete. A Daily Census Report dated 02/24/2025, documented there were 18 empty beds in the facility. The facility's Monthly Line Listing of infections for February 2025, documented Resident #32 had a UTI. The date of infection was listed as 02/13/2025. The pathogen/organism was E. coli ESBL, the infection was healthcare associated, and contact precautions were initiated. Resident #32's clinical record documented on 02/13/2025, the resident was sharing a room with Resident #27. The facility's Monthly Line Listing of infections for March 2025, documented Resident #27 had a UTI. The date of infection was listed as 03/25/2025. The pathogen/organism was E. coli, the infection was healthcare associated, and contact precautions were initiated. The facility's CNA and nurse schedule for March 2025 documented one nurse worked in the facility during the night shift on 03/01/2025 through 03/05/2025. (continued on next page)

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/29/2025 at 4:32 PM, the DON explained an adequate number of staff to care for residents in the facility varied by acuity. At a minimum, the facility would staff one nurse and three CNAs at night. The DON confirmed the facility had shifts when only one nurse was in the facility to provide nursing care to all residents. On 04/30/2025 at 2:27 PM, the IP explained the first time the facility was aware of and had documentation of Resident #27 testing positive for ESBL E. coli was 03/25/2025, after sharing a room with Resident #32. The facility's Monthly Line Listing of infections for March 2025, documented Resident #27 had a UTI. The date of infection was listed as 03/25/2025. The pathogen/organism was E. coli, the infection was healthcare associated, and contact precautions were initiated. The facility policy titled Transmission Based Precautions, published 01/2025, documented it was the policy of the facility to implement Transmission-Based Precautions (TBP) for residents known to be, or suspected of being, infected with infectious agents. The four types of TBP included contact, droplet, airborne, and enhanced barrier precautions. The need to implement TBP was determined by the IP, DON, and/or consultation with the local health department. Precautions were based on CDC guidelines. Contact, or touch, was the most common and most significant mode of transmission of infectious agents. Contact transmission could occur by directly touching the resident, through contact with the resident's environment, or by using contaminated gloves or equipment. Options for residents on contact precautions could include a private room, cohorting with another infected or colonized resident or sharing a room with a resident with limited risk factors. The CDC document titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated 09/2024, documented MDROs were generally defined as microorganisms which were resistant to one or more classes of antimicrobial agents. MDROs of concern included those producing ESBL. Documented outbreaks in long-term care facilities were caused by various viruses and bacteria and could lead to substantial morbidity and mortality and increased medical costs. Prompt detection and implementation of effective control measures were required. Placement of a resident in a single room was preferred when there was concern about transmission of an infectious agent, including residents on contact and droplet precautions. Recommendations for residents infected or colonized with an MDRO judged as clinically important by the infection control program included contact in addition to standard precautions. Enhanced Barrier Precautions Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including other low back pain and fusion of spine, cervical region. A Weekly Skin Evaluation dated 04/23/2025, documented an unstageable pressure injury on Resident #6's coccyx. The wound measured 10 centimeters in length and 9 centimeters in width. The documented dressing order was: cleanse with wound cleanser, pat dry, apply hydrogel sheet, apply padded foam bordered dressing, apply barrier cream surrounding bordered dressing. Wound care was to be provided daily and as needed. (continued on next page)

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the genitourinary system and encounter for fitting and adjustment of urinary device. A Physician's Order dated 04/13/2025, documented Foley catheter size 22 French (FR), balloon 30 cubic centimeters (cc). Change as needed for damage, occlusion, or obtaining urinalysis (UA). Resident #20 Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the genitourinary system and encounter for fitting and adjustment of urinary device. A Physician's Order dated 04/09/2025, documented Foley catheter size 16 FR, balloon ten cc. Change as needed for damage, occlusion, or obtaining a UA. On 04/28/2025 at 7:29 AM, during a tour of the facility, no EBP signage and PPE cart was located outside the rooms of Resident #6, #15, and #20. On 04/29/2025 at 11:33 AM, during a tour of the facility, no EBP signage and PPE cart was located outside the rooms of Resident #6, #15, and #20. On 04/29/2025 at 3:33 PM, during an interview with the DON and the IP, the DON verbalized the intent of EBP was to protect residents from contracting organisms in the facility. The DON explained EBP was to be used for residents with open wounds, feeding tubes, and Foley catheters. The DON and IP confirmed Resident #20 and Resident #15 had indwelling Foley catheters in place and Resident #6 had an open wound. The DON and IP confirmed Residents #20, #15, and #6 did not have EBP in place. The facility policy titled Transmission Based Precautions, published 01/2025, documented when a resident was colonized with an MDRO or the status of colonization was unknown, EBP was utilized per CDC guidance to reduce the spread of an MDRO. Residents requiring EBP regardless of confirmed MDRO status included residents with tracheostomies, wound, enteral tubes, central IV catheters, and urinary catheters. Staff caring for a resident on EBP were to wear a gown and gloves during the following: dressing, bathing, transferring, providing hygiene, changing linens or briefs, device care, and wound care. Cross reference tag F690.

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	05/01/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on clinical record review, interview, and document review the facility failed to ensure 1 of 5 residents sampled for vaccinations (Resident #12) was offered timely pneumococcal vaccination to complete the recommended pneumococcal vaccine schedule. This deficient practice had the potential to result in residents contracting a preventable illness. Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus with other circulatory complications and chronic diastolic (congestive) heart failure. Resident #12's Immunization Audit Report documented the resident had received the 23-valent pneumococcal polysaccharide (PPSV23) vaccine on 06/17/2021, 12/03/2018, and 10/15/2013. The Immunization Audit Report and Resident #12's clinical record lacked documentation the resident previously received any other pneumococcal vaccines. The following vaccines were documented as pending immunization: PCV13, PPSV23, PCV15, and PCV20. A Resident Multi-Vaccine Consent Form dated 04/13/2025, documented Resident #12 was eligible for the pneumococcal vaccine. The form lacked a signature from the resident/resident representative consenting to or declining the vaccine. On 04/29/2025 at 3:55 PM, the Infection Preventionist (IP) explained the facility determined a resident's eligibility for the pneumococcal vaccine based on the resident consenting to the vaccine, if the resident had received the vaccine in the past, and per Centers for Disease Control and Prevention (CDC) recommendations. The IP verbalized the IP had been working to screen all residents in the facility for vaccination history and eligibility to receive various vaccines. On 05/01/2025 at 4:29 PM, the IP verbalized if a resident was eligible for a vaccine, the IP would document pending immunization in the resident's record. The IP verbalized pending immunization indicated the resident gave consent and was due/eligible for the vaccine/s. The IP confirmed Pneumococcal Conjugate Vaccine (PCV) vaccines PCV20, PCV21, and PCV15 had not been administered to Resident #12. The CDC document titled Pneumococcal Vaccine Timing for Adults, dated 10/2024, documented for adults [AGE] years or older who had received a PPSV23 vaccine at any age, the complete pneumococcal vaccine schedule included two options. Option A was to offer the PCV20 or PCV21 one year or more after the last dose of PPSV23. Option B was to offer PCV15 one year or more after the last dose of PPSV23. (continued on next page)

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	05/01/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Influenza and Pneumococcal Vaccine Administration, updated 02/2025, documented pneumococcal vaccination occurred with residents, upon admission and with repeated vaccination occurring per CDC guidelines. Licensed nursing staff were to review and evaluate potential contraindications with residents via the current version of the CDC Pneumococcal Vaccine Information Sheet. The electronic health record was maintained with documentation of residents who received the vaccine, as well as those who refused or did not get vaccinated.

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	05/01/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on clinical record review, interview, and document review the facility failed to ensure 1 of 5 residents sampled for vaccinations (Resident #4) received or declined an updated/booster dose of COVID-19 (Covid) vaccine after being screened for eligibility. This deficient practice placed residents wishing to receive the Covid vaccine at risk of not receiving the vaccine and experiencing severe or prolonged illness, hospitalization , or death as a result of infection with the Covid virus. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications and hypertension. Resident #4's Immunization Audit Report lacked documented evidence the resident had received any doses of the covid vaccine. The form documented a status of pending immunization for covid vaccine, entered by the Infection Preventionist (IP) on 04/13/2025. A Resident Multi-Vaccine Consent Form dated 04/13/2025, documented Resident #4 was eligible for the covid vaccine. The form lacked a signature from the resident/resident representative consenting to or declining the vaccine. Resident #4's clinical record lacked documented evidence the covid vaccine was administered or declined. On 04/29/2025 at 3:55 PM, the IP explained the facility determined a resident's eligibility for the covid vaccine based on the resident consenting to the vaccine, if the resident had received the vaccine in the past, and per Centers for Disease Control and Prevention (CDC) recommendations. The IP verbalized the IP had been working to screen all residents in the facility for vaccination history and eligibility to receive various vaccines. On 04/30/2025 at 3:33 PM, the IP confirmed Resident #4's clinical record lacked documentation of previous vaccination with the covid vaccine and the resident should have received or declined the vaccine. On 05/01/2025 at 4:29 PM, the IP verbalized if a resident was eligible for a vaccine, the IP would document pending immunization in the resident's record. The IP verbalized pending immunization indicated the resident gave consent and was due/eligible for the vaccine/s. The IP confirmed the covid vaccine had not been adminsitered to Resident #4. (continued on next page)

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	05/01/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A CDC document titled Stay Up to Date with COVID-19 Vaccines, updated 01/07/2025, documented everyone ages six months and older should get a 2024-2025 COVID-19 vaccine. Getting the 2024-2025 COVID-19 vaccine was especially important if you lived in a long-term care facility. People ages 65 and older were considered up to date with covid vaccines when two doses of any 2024-2025 COVID-19 vaccine had been administered. It was recommended to administer the doses six months apart, with a minimum interval of two months in between doses. The facility policy titled SARS-CoV-2 (COVID-19) SNF, published 01/2025, documented the facility followed current CDC guidelines and recommendations to minimize exposure to respiratory pathogens including the virus causing COVID-19. Residents were to be offered recommended COVID-19 vaccinations upon admission and as eligible per CDC recommendations. A fact sheet including the risks and benefits of the vaccine was to be provided prior to offering the vaccine. Vaccine declination was to be documented in the resident's record and a log was to be maintained for those who accepted or declined vaccination.