

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER Gardnerville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1573 South Muller Pkwy Gardnerville, NV 89410	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to ensure 5 of 5 residents reviewed for immunizations (Resident #15, #5, #59, #46, and #1) were eligible to receive pneumococcal vaccines by failing to assess immunization status, determine if additional vaccine doses were indicated based on current Center for Disease Control and Prevention (CDC) recommendations and identifying contraindications or precautions prior to making a vaccine determination. This deficient practice resulted in Substandard Quality of Care and had the potential for residents to receive unnecessary vaccines and for eligible residents to not be offered recommended immunizations, placing the residents at increased risk for developing vaccine-preventable illnesses, including pneumococcal disease. Findings include: Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia, type II diabetes mellitus without complications, chronic kidney disease stage 3B, and acute diastolic (congestive) heart failure. A diagnosis of pneumonia, unspecified organism, was added on 06/23/2026. A document titled Standing Vaccine Consent and Administration Form signed by the resident on 06/08/2026 did not document screening for eligibility. Resident #15's Nevada Immunization Record ([NAME]) documented the resident was administered one dose of Pneumococcal Conjugate Vaccine (PCV) 20 on 06/07/2024, prior to being admitted to the facility. The CDC application (app), titled PnuemoRecs VaxAdvisor, indicated when Resident #15 was administered a dose of PCV-20 on 06/07/2026, the resident's pneumococcal vaccines were up to date, and the resident did not require additional pneumococcal vaccines. Resident #15's electronic health record (EHR) included a facility Immunization Report. The facility Immunization report did not include the following documentation: -Documentation Resident #15 had been screened for eligibility to receive a pneumococcal vaccine including if the resident was up to date with pneumococcal vaccines or was eligible to receive a pneumococcal vaccine per CDC recommendations. -Documentation regarding a pneumonia vaccine, including Resident #15 was administered one dose of PCV-20 on 06/07/2024, prior to being admitted to the facility or at any other time. -Documentation Resident #15 was up to date with pneumococcal vaccines and an additional dose was not necessary. On 06/25/2026 at 12:11 PM, the Infection Preventionist (IP) verbalized the expectation was information regarding a resident's influenza and pneumococcal vaccination status was to be documented in the resident's EHR under the immunization tab. The IP explained the IP did not have a tool available to screen residents for eligibility to receive an influenza or pneumococcal vaccine and documented by exception only. The IP confirmed the IP did not screen residents for eligibility to receive the vaccines, including allergies and contraindications. On 06/25/2026 at 12:16 PM, the IP explained when a new resident was admitted to the facility the expectation was the admitting nurse would ask the resident if the resident would like to receive a pneumococcal and/or influenza vaccine. The IP followed up with the resident and asked (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 295082	Facility ID: 295082 If continuation sheet Page 1 of 31

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	if the resident wanted to receive the vaccines and entered the resident's response into the resident's facility immunization record. Resident #5Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encephalopathy, unspecified, type 2 diabetes mellitus with other specified complications, chronic obstructive pulmonary disease, unspecified, other pulmonary embolism without acute core pulmonale, and fragile X chromosome. A document titled Standing Vaccine Consent and Administration Form signed by Resident #5's representative on 02/24/2025, did not document screening for eligibility to receive vaccines, including influenza and pneumococcal vaccines.Resident #5's [NAME] documented the resident last received an influenza vaccine on 10/22/2024 and was administered one dose of PCV-13 on 11/19/2017, and one dose of Pneumococcal Polysaccharide Vaccine (PPSV -23) on 10/05/2018.The CDC application (app), titled PneumoRecs VaxAdvisor, indicated Resident #5 was eligible to receive one dose of either PCV-20 or PCV-21, based on the resident's age, and the length of time following the last pneumococcal vaccine received.Resident #5's EHR included an Immunization Report, and the report documented the status for influenza and pneumococcal vaccine as refused but did not include the date the vaccines were refused. The facility did not provide documentation of screening for eligibility to receive a pneumococcal or influenza vaccine.On 06/25/2026 at 12:23 PM, the IP confirmed resident #5's EHR did not include documentation the resident was screened for eligibility to receive an influenza or pneumococcal vaccine. Resident #59Resident #59 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paraplegia, unspecified, pressure ulcer right buttock, stage 4, chronic vascular disorders of the intestine, resistance to multiple antimicrobial drugs, unspecified severe protein calorie malnutrition, and methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere.A facility document titled Residential Multi-Vaccine Consent Form revised 10/13/2023, completed on 06/02/2025 did not document screening for eligibility to receive vaccines, including influenza and pneumococcal vaccines.Resident #59's EHR included an Immunization Report, and the report documented influenza and pneumococcal vaccines were refused but did not include the date of refusal and did not document if any vaccines were previously administered. The facility did not provide documentation of screening for eligibility to receive a pneumococcal or influenza vaccine.On 06/25/2026 at 12:24 PM, the IP confirmed Resident #59 was not screened for eligibility to receive influenza or pneumococcal vaccines. Resident #46Resident #46 was admitted to the facility on [DATE], with diagnoses including sick sinus syndrome, moderate protein-calorie malnutrition, and cognitive communication deficit.A facility document titled Residential Multi-Vaccine Consent Form revised 10/13/2023, completed on 02/26/2025 did not document screening for eligibility to receive vaccines, including influenza and pneumococcal vaccines.Resident #46's [NAME] documented the resident last received an influenza vaccine on 08/22/2023 and received one dose of PCV-13 on 09/14/2021, and one dose of PCV-20 on 12/28/2022.The CDC application (app), titled PneumoRecs VaxAdvisor, indicated Resident #46's pneumococcal vaccine was up to date when the resident was administered PCV-20 on 12/28/2022, and vaccination with additional pneumococcal vaccine was not necessary. Resident #46's facility Immunization Report documented the following-An influenza vaccine was administered at the facility on 10/22/2025, but lacked documentation an influenza vaccine was administered when the resident admitted to the facility during the 2024/2025 influenza season. -A dose PCV-13 was refused, and the entry was not dated. -The resident was not eligible to receive a dose of PCV-20, the date and/or the reason the resident was not eligible to receive a pneumococcal vaccine was not documented. -On 05/22/2025, the facility administered one dose of PCV-20 to Resident #46 when the CDC recommendation indicated an additional dose of a pneumococcal vaccine was not necessary. On (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide sufficient nursing staff to meet the needs of residents as identified in the facility assessment for 6 of 25 reviewed days. This deficient practice had the potential to result in staffing levels below the facility established Per Patient Day (PPD) requirements and had the potential to negatively affect resident care, safety, and timely delivery of services. Findings include: The Facility Assessment revised 08/26/2025, documented the following required daily staffing levels: Certified Nursing Assistant (CNA): 105.04 hours per day, equal to 8.75 CNAs per day. Review of June 2026 staffing schedules revealed the following: 06/01/2026, the June 2026 actual staffing schedule documented seven CNAs worked. 06/06/2026, the June 2026 actual staffing schedule documented seven CNAs worked. 06/08/2026, the June 2026 actual staffing schedule documented six CNAs worked. 06/13/2026, the June 2026 actual staffing schedule documented five CNAs worked. 06/14/2026, the June 2026 actual staffing schedule documented seven CNAs worked. 06/20/2026, the June 2026 actual staffing schedule documented seven CNAs worked. On 06/25/2026 at 11:14 AM, the Scheduler/CNA verbalized staffing needs were determined by the Per Patient Day (PPD) requirements based on the census to ensure adequate staffing. The Scheduler/CNA stated the facility's average census was 55 residents, with an average of five to six CNAs during AM shifts and three to four CNAs during PM shifts. The Scheduler/CNA explained sufficient staffing was necessary to meet resident needs, showers, care tasks, and safety. The Scheduler/CNA confirmed 06/01/2026, 06/06/2026, 06/08/2026, 06/13/2026, 06/14/2026 and 06/20/2026 the CNAs worked did not meet the minimum CNA PPD requirement set by the facility. The Facility Assessment revised 08/26/2025, documented the facility would make a good effort to evaluate the overall number of facility staff needed to ensure enough qualified staff were available to meet each resident's needs.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and document review, the facility failed to ensure 1) medications were accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication and 2) 2 of 2 medication storage carts were kept clean and organized when medications which were contaminated and/or in a container without a secure closure were not immediately removed from stock and disposed of. This deficient practice had the potential to result in unauthorized access to medication, misuse of medication within the facility and contaminated medication to be administered to residents. Findings include: Unauthorized access to medications On 06/24/2026 at 2:02 PM, a Certified Nursing Assistant (CNA) entered a code on the keypad to the central supply room door and entered the room. On 06/24/2026 at 2:05 PM, the CNA verbalized the central supply room was used to store briefs, personal care supplies and medical stuff including bandages, catheters, and alcohol. The CNA confirmed medications were stored in the room and verbalized CNAs and nurses could access the room. On 06/24/2026 at 2:10 PM, two large metal cabinets were observed in the central supply room. Both cabinets had two doors. The cabinet doors were unlocked and left partially open, with various medications stored inside. The Minimum Data Set 3.0 (MDS) Coordinator verbalized nurses, CNAs, the Administrator and maintenance employees had access to the central supply room. The MDS Coordinator confirmed the cabinets contained medications and were left unlocked. The MDS Coordinator verbalized the cabinets were usually left unlocked because of the lock on the supply room door. On 06/25/2026 at 11:30 AM, the MDS Coordinator denied CNAs and maintenance employees were authorized to administer medication and should have access to medication. The facility policy titled Storage of Medication, dated 09/2018, documented the medication supply was to be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, cabinets and medication supplies were to remain locked when not in use or attended by persons with authorized access. Medication storage On 06/24/2026 at 2:26 PM, during an inspection of the 100-hall medication cart, a white, oblong-shaped medication tablet was observed at the bottom of a drawer in the cart. The tablet was loose and not packaged. On 06/24/2026 at 2:35 PM, the MDS Coordinator confirmed the tablet was loose at the bottom of the drawer, donned a glove and removed the tablet from the drawer. On 06/24/2026 at 2:57 PM, during an inspection of the 500-hall medication cart, the following were observed in various drawers in the cart and confirmed by the MDS Coordinator: -A small, round white medication tablet lying at the bottom of a drawer. -A small, round yellow medication tablet lying at the bottom of a drawer. -A lidocaine patch lying on a purple, plastic tray at the bottom of a drawer. The patch was open and lacked a package. -A lidocaine patch in a drawer. The package was open and the patch was exposed. On 06/24/2026 at 3:12 PM, the MDS Coordinator verbalized opened items in the medication cart could be an infection control issue as patches were going directly on residents' skin. Loose tablets without packaging were a safety issue since the tablets were no longer labeled and staff would not know what the medications were. Additionally, the tablets were an infection control concern and could be contaminated or tampered with. The facility policy titled Storage of Medication, dated 09/2018, documented medication storage should be kept clean, well lit, organized and free of clutter. Outdated, contaminated, discontinued or deteriorated medications and those in containers which were cracked, soiled, or without secure closures were to be immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order existed.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to make prompt efforts to resolve grievances when a grievance form was not given to facility leadership timely for 1 of 14 sampled residents (Resident #40). This deficient practice had the potential to result in residents having unresolved complaints/grievances. Findings include: Resident #40 Resident #40 was admitted to the facility on [DATE], with a diagnosis of emphysema, unspecified. On 06/22/2026 at 12:31 PM, Resident #40 was seated at a table in the dining room on the 500 unit. Resident #40 informed a Certified Nursing Assistant (CNA), the resident was unable to locate the resident's lower denture. The resident verbalized the resident was not sure if the dentures were left in the resident's pocket when the clothing went to laundry or if the denture was left on a meal tray. The CNA verbalized the CNA would let someone know. On 06/22/2026 at 1:53 PM, Resident #40 verbalized Resident #40 recently received new dentures, and the lower denture was lost. The resident denied having any difficulty chewing or swallowing. On 06/25/2026 at 9:49 AM, the Administrator verbalized the Administrator handled all grievances and explained when a grievance was received, the Administrator typically discussed the concern at the facility's standup meeting the following day. The Administrator confirmed the Administrator was familiar with Resident #40's missing dentures and verbalized the Administrator did not have a grievance related to the dentures as the Administrator thought the dentures had been located. On 06/25/2026 at 11:00 AM, the Administrator provided a copy of a Grievance Form. The Grievance form was dated 06/22/2026 and documented Resident #40's bottom dentures were missing. The resident had the dentures in the resident's pocket because they bothered the resident. The CNA searched all pockets, bathroom, etc. and did not find the dentures. On 06/25/2026 at 11:05 AM, the Administrator explained Resident #40 informed the Activities Director (AD) the resident's dentures were missing on 06/22/2026. The AD filled out a grievance form and slipped the grievance form under the Director of Nursing (DON)'s office door however; the DON had not been present in the building all week. The Administrator verbalized staff were expected to ensure the Administrator and/or the DON were notified of all grievances right away. The Administrator confirmed by placing the grievance form under the DON's office door when the DON was not working for several days and failure to notify the Administrator of the grievance resulted in a delayed response to the grievance. The Administrator verbalized dentures were important for residents and missing dentures could cause discomfort or a resident may not be able to eat. The facility policy titled Grievance Procedure, updated 11/2016, documented staff were trained at orientation and periodically on the facility's grievance procedure, including: the need to take grievances seriously, what to do with grievances, when to put a grievance in writing, and when to report to the supervisor and to the state according to mandated reporting requirements. Grievances were resolved immediately, when possible, by the individual receiving the grievance. When immediate resolution was not possible, the grievance was routed to the grievance official and/or social services/designee within 24 hours. The individual receiving the grievance filled out a grievance form and Social Services/designee logged the grievance on the grievance log. The Executive Director reviewed the grievance log at the daily standup meeting for needed resolution and/or follow up.		

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an initial care plan for a peripherally inserted central catheter (PICC) line for 1 of 14 sampled residents (Resident #59). This failure created the potential for unmet care needs related to management of the PICC line. Findings include: Resident #59 Resident #59 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including urinary tract infections, resistance to multiple antimicrobial drugs, and paraplegia. Resident #59 care plan initiated on 11/17/2025 and revised on 06/11/2026 lacked documented evidence a care plan was developed for Resident #59's PICC line. On 06/29/2026 at 10:40 AM, the Minimum Data Set (MDS) Coordinator verbalized a care plan would be required for a PICC line and confirmed an initial care plan was not created for Resident #59. The Resident Assessment Instrument (RAI) 3.0 manual, Chapter 2, the Care Area Assessment (CAA) Process and Care Plan Completion dated 10/2025, documented the residents' plan of care would be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The resident's care plan would be revised based on changing goals, preferences, and needs of the resident and in response to current interventions.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER Gardnerville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1573 South Muller Pkwy Gardnerville, NV 89410	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure care plans were developed related to 1) the monitoring and supervision of high-risk medications including narcotics and diuretics, 2) the care of indwelling devices, and 3) pain management for 3 of 14 sampled residents (Resident #38, #5, and #18). This deficient practice had the potential to result in residents not receiving the necessary care and services to ensure medications were monitored for the appropriate side effects including increased risk for falls, severe hypotension, constipation, bowel impaction, and complications related to other potential side effects of narcotic and diuretic medications, increased risk for catheter-associated urinary tract infections (CAUTIs), and unrelieved pain. Findings include: Resident #38 Resident #38 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified, urinary tract infection, site not specified, and pressure ulcer of the sacral region, stage III. A Physician Order dated 02/20/2026, documented spironolactone 25 milligram (mg) oral tablet, give one tablet by mouth one time a day for diuretic, hold for a systolic blood pressure less than 90, monitor for signs and symptoms of dehydration. A Physician Order dated 05/20/2026 documented methadone hydrochloride (HCl), give 2.5 mg by mouth three times a day for chronic pain, for 30 days. A Physician Order dated 06/03/2026 documented Dilaudid (hydromorphone) 2 milligram (mg) oral tablets, give 0.5 tablets by mouth every six hours as needed for pain. Resident #38's Comprehensive Care Plan did not include a care plan related to the use and monitoring of methadone, dilaudid and spironolactone. On 06/29/2026 at 12:58 PM, the Minimum Data Set (MDS) Coordinator confirmed Resident #38's Comprehensive Care Plan did not include a care plan related to the use of methadone, dilaudid, or spironolactone. The MDS Coordinator verbalized it was important to have the medications care planned to inform staff the resident needed to be monitored for concerns related to side effects of the medications. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Osteomyelitis of vertebra, sacral and sacrococcygeal region, diabetes mellitus 2 with neuropathy, and stage 4 pressure ulcer to sacrum. On 06/22/2026 at 9:15 AM, Resident #5 had a Foley catheter in place. The drainage bag was secured to the bed frame, and clear yellow urine was in the bag. The resident representative verbalized the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had a Foley catheter in place. A Minimum Data Set (MDS) admission assessment, completed 03/20/2025, documented Resident #5 had an indwelling catheter. A Physicians Order dated 03/11/2025, documented Foley catheter 16Fr with 30cc balloon, clean Foley site every day and evening shift for skin impairment management. On 06/24/2026 at 3:23 PM, during a review of Resident #5's care plan, the care plan included a focus area of enhanced barrier precautions related to the catheter. The care plan for Resident #5 lacked a plan for addressing Resident #5's Foley catheter care interventions and goals. A Progress Note dated 03/16/2025, documented Resident #5's catheter was leaking, sterile gloves donned, saline water 5 milliliters (ml) inserted, 18 ml withdrawn, urine return still noted, filled foley balloon per order with 30 ml of saline. On 06/25/2026 at 2:44 PM, the Registered Nurse (RN) verbalized a care plan for a resident with a Foley catheter should include monitoring for signs and symptoms of infection, cleaning of the insertion site, assuring privacy cover was in place over the drainage bag, keeping the drainage bag below the level of the bladder, and changing of the catheter. On 06/25/2026 at 3:34 PM, the acting Director of Nursing (DON) verbalized a care plan for a resident with a Foley catheter should include interventions and goals related to signs and symptoms of infection, cleaning of the insertion site, assuring privacy cover was in place over the drainage bag, keeping the drainage bag below the level of the bladder, and changing of the catheter. The acting DON confirmed a focus area related to the care of the resident's catheter was not on Resident #5's care plan. The Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 RAI User's Manual, version 1.1.9.1, documented the facility was to develop a care plan for each resident which included measurable objectives and timeframes, and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan was to be revised on an ongoing basis to reflect changes in the resident and care the resident was receiving. Resident #18 Resident #18 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, unspecified and major depressive disorder, recurrent, moderate. On 06/22/2026 at 11:09 AM, Resident #18 verbalized pain management was a big issue for the resident. The resident had pain in the resident's back, left leg, and shoulder. For pain control, the resident took oxycodone 30 milligrams every three hours. The pain medication kept the pain at a tolerable level. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Minimum Data Set 3.0 (MDS) assessment dated [DATE], section J, documented Resident #18 had pain almost constantly. The pain, rated at its worst, was a 10 on a 0-10 scale. Resident #18's Care Plan documented the resident had pain which interfered with sleep, rehabilitation activities, and day to day activities. Goals included the resident would voice a level of comfort of (SPECIFY residents states range of comfort) out of (SPECIFY) through the review date. Interventions included the following: -The resident's pain is aggravated by: (SPECIFY) -The resident's pain is alleviated/relieved by: (SPECIFY) -Monitor/record pain characteristics (SPECIFY FREQ) and PRN: quality, severity, anatomical location, onset, duration, aggravating factors, relieving factors. -The resident is able to: (SPECIFY: call for assistant when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain). On 06/25/2026 at 3:54 PM, the MDS Coordinator verbalized the care plan for residents with pain should include interventions such as assessing objective and subjective manifestations of pain, administering pain medication as prescribed, monitoring for side-effects, and offering non-pharmaceutical pain management interventions. On 06/25/2026 at 4:45 PM, the MDS Coordinator reviewed Resident #18's Care Plan and confirmed the Care Plan related to pain was not resident-specific due to several areas reflecting SPECIFY and not being filled with in the resident's level of comfort, aggravating factors, alleviating factors and frequency of pain monitoring. On 06/25/2026 at 5:02 PM, the MDS Coordinator denied the facility had a policy related to care planning and explained the facility followed the Resident Assessment Instrument 3.0 (RAI) manual. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, updated 10/2025, documented the MDS was to be analyzed and combined with other relevant information to develop and individualized care plan. The care plan was to be revised on an ongoing basis to reflect changes in the resident and the care the resident was receiving.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure staff received training and were deemed competent by the facility to provide care to Peripherally Inserted Central Catheters (PICCs) prior to being assigned to care for 1 of 14 sampled residents (Resident #59). This deficient practice had the potential to result in insertion site and blood stream infections for residents due to lack of knowledge of correct technique for dressing changes and signs and symptoms of potential complications. Findings include: Resident #59 Resident #59 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses including resistance to multiple antimicrobial drugs, urinary tract infection and neuromuscular dysfunction of bladder. On 06/22/2026 at 2:20 PM, Resident #59 verbalized having been in the facility since 2025 and recently transferred to the hospital for a severe urinary tract infection with blood in the urine. Resident #59 reported having an indwelling catheter. Observation revealed a PICC line dressing dated 06/14/2026. Resident #59 was receiving IV antibiotics through the PICC line. A Physician's Order dated 06/11/2026, documented PICC site maintenance with transparent and gauze dressing changes 24 hours post insertion, then every seven days and as needed. The order directed staff to measure upper arm circumference 10 centimeters (cm) above external catheter length. If gauze was present, dressings were to be changed every 48 hours until 06/24/2026. Resident #59's June 2026 Intravenous (IV) Treatment Administration Record (TAR) documented the same PICC site maintenance and measurement requirements. The TAR documented dressing care was completed by Licensed Practical Nurse (LPN)1 on 06/16/2026 and 06/23/2026. The IV TAR also documented PICC flush orders using 5 milliliters (ml) normal saline before and after infusion, twice daily, until 06/24/2026. The TAR documented the central line flush orders were administered by the following staff members on the following dates: -LPN1 on 06/15/2026, 06/16/2026, 06/22/2026 and 06/23/2026. -LPN2 on 06/12/2026, 06/13/2026, 06/18/2026, 06/19/2026 and 06/20/2026 -LPN3 on 06/14/2026. -LPN4 on 06/20/2026. On 06/24/2026 at 5:12 PM, the Minimum Data Set (MDS) Coordinator explained dressings for PICC lines were to be changed every seven days or if soiled or dislodged. PICC line flushing was to occur daily during every shift. The importance of dressing changes was for infection prevention, keeping line patent and usable. The MDS Coordinator verbalized, not knowing when the dressing was last changed. The Regional Director of Clinical Operations (RDCO) reported the TAR documented a dressing change on 06/23/2026. The RDCO stated Resident #59 completed IV antibiotics on 06/22/2026 and flushing had been occurring twice daily. The RDCO reported PICC orders were discontinued on 06/23/2026 and no flush was completed on 06/23/2026. A new flush order would have been required for continued PICC maintenance. On 06/24/2026 at 5:21 PM, the MDS Coordinator confirmed Resident #59's bandage remained dated 06/14/2026 and should have been changed by 06/21/2026. The MDS Coordinator verbalized it was not appropriate for the TAR to document completed dressing changes when the date on the dressing did not correspond. On 06/25/2026 at 3:52 PM, the MDS Coordinator verbalized an LPN must be IV certified to perform PICC line flushes. On 06/29/2026 at 10:55 AM, the MDS Coordinator explained the Director of Nursing was responsible for ensuring staff had appropriate certifications and competencies prior to being assigned PICC care. The MDS Coordinator confirmed LPN1 lacked documented IV certification and was documenting dressing changes as completed even though the dressing appeared unchanged. The facility document titled Infusion Therapy Procedures - Dressing Change for Vascular Access Devices, dated 08/2016, documented initial dressings must be changed PRN if saturated, and 24-48 hours (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	post insertion for midlines, PICCs, or other central venous access devices if gauze or drainage was present. Transparent dressings with Biopatch may remain for seven days unless compromised. The facility's LPN job description documented essential functions includes dresses wounds and administer specified medication intravenously and notes time and about on resident charts (as allowed by state law). Nevada Administrative Code (NAC) 632.242, documented an LPN may perform specialized skills within their scope only if they maintain original documentation of training and annual verification of continued competency. The Lippincott Manual of Nursing Practice (12th ed., 2025) documented the importance of routine and as needed IV dressing changes, including changing transparent dressings every seven days and replacing any dressing that becomes damp, loose, or soiled. The CDC document titled Summary of Recommendations: Guidelines for the Prevention of Intravascular Catheter-Related Infections, dated 02/28/2024, documented the following:-Recommendations for catheter education, training, and staffing: Educate healthcare personnel regarding the indications for intravascular catheter use, proper procedures for the insertion and maintenance of intravascular catheters, and appropriate infection control measures to prevent intravascular catheter-related infections. Designate only trained personnel who demonstrate competence for the insertion and maintenance of peripheral and central intravascular catheters. Periodically assess knowledge of and adherence to guidelines for all personnel involved in the insertion and maintenance of intravascular catheters.-Recommendations for catheter site dressing regimens: Replace catheter site dressing if the dressing becomes damp, loosened or visibly soiled. Replace dressing used on short-term central venous catheters (CVCs) at least every seven days for transparent dressings. Replace dressings every two days for gauze dressings. Cross reference tag F694.		

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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** Based on observation, interview, and record review, the facility failed to ensure a resident received timely bathing, hygiene, and personal care services consistent with the resident's needs and preferences for 1 of 14 sampled residents (Resident #44). This deficient practice had the potential to result in residents not receiving routine bathing services, caused extended periods without showers, and failed to maintain dignity, comfort, and basic hygiene. Findings include: Resident #44 Resident #44 was admitted on [DATE], with diagnoses including need for assistance with personal care, psychosis, and major depressive disorder. On 06/22/2026 at 11:22 AM, Resident #44 verbalized not receiving scheduled showers on Sundays and Wednesdays. The resident stated scheduled showers don't happen, reported going 23 days without a shower, and stated the last shower received was on 06/21/2026. The resident described feeling dirty and crappy due to not receiving routine bathing. Resident #44's Documentation Survey Report V2 for May 2026 lacked documentation of a shower provided or declined from 05/03/2026 to 05/13/2026 (13 days) and from 05/17/2026 to 05/27/2026 (nine days). Resident #44's Care Plan dated 07/07/2025, documented Resident #44 activities of daily living self-care performance deficit and needed assistance with personal care. Resident #44 prefers showering two days per week, requiring one staff assistance. On 06/24/2026 at 2:40 PM, a Certified Nursing Assistant (CNA) explained residents were scheduled for showers two times per week. The CNA stated staff were responsible for offering a shower or an alternative if the residents declined. Staff were expected to transport the resident to the shower room and return the resident afterward. The CNA was unsure which days Resident #44 received showers. A shower aide was scheduled for 06/24/2026, but the CNA was unsure if a shower occurred. The CNA stated staff were expected to complete skin and hygiene sheets and verbalized it would not be appropriate for a resident to go more than two weeks without being offered a shower. On 06/24/2026 at 2:45 PM, a Registered Nurse (RN) explained CNAs had a daily list of assigned showers. If a resident needed assistance or refused, staff were expected to educate the resident and attempt transport to the shower room. The RN stated shower sheets were provided to nurses after bathing to identify new skin issues and staff were required to sign and chart shower documentation in the resident's Electronic Health Record (EHR). On 06/24/2026 at 4:18 PM, the Infection Preventionist (IP) stated if a shower was not documented, it did not occur. The IP verbalized Resident #44 required a one-person assist in the shower and a two-person transfer from bed to chair and was dependent on staff for bathing. The IP confirmed the lack of shower documentation for Resident #44 and stated it was important for the residents to receive showers for skin condition, overall health, and infection prevention. The Administrator and IP reported there was no facility-specific shower policy and staff followed CMS guidance. Cross reference tag F842.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure Peripherally Inserted Central Catheter (PICC) line dressing changes were performed according to physician orders for 1 of 14 sampled residents (Resident #59). This deficient practice had the potential to result in insertion site and bloodstream infections for residents. Findings include: Resident #59 Resident #59 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses including resistance to multiple antimicrobial drugs, urinary tract infection and neuromuscular dysfunction of bladder. On 06/22/2026 at 2:20 PM, Resident #59 verbalized having been in the facility since 2025 and recently transferred to the hospital for a severe urinary tract infection with blood in the urine. Resident #59 reported having an indwelling catheter. Observation revealed a PICC line dressing dated 06/14/2026. Resident #59 was receiving IV antibiotics through the PICC line. A Physician's Order dated 06/11/2026, documented PICC site maintenance with transparent and gauze dressing changes 24 hours post insertion, then every seven days and as needed. The order directed staff to measure upper arm circumference 10 centimeters above external catheter length. If gauze was present, dressings were to be changed every 48 hours until 06/24/2026. Resident #59's June 2026 Intravenous (IV) Treatment Administration Record (TAR) documented the same PICC site maintenance and measurement requirements. The TAR documented dressing care was completed by LPN1 on 06/16/2026 and 06/23/2026. On 06/24/2026 at 5:12 PM, the Minimum Data Set (MDS) Coordinator explained dressings for PICC lines were to be changed every seven days or if soiled or dislodged. The importance of dressing changes was for infection prevention, keeping line patent and usable. The MDS Coordinator verbalized, not knowing when the dressing was last changed. The Regional Director of Clinical Operations (RDCO) reported the TAR documented a dressing change on 06/23/2026. On 06/24/2026 at 5:21 PM, the MDS Coordinator confirmed Resident #59's bandage remained dated 06/14/2026 and should have been changed by 06/21/2026. The MDS Coordinator verbalized it was not appropriate for the TAR to document completed dressing changes when the date on the dressing did not correspond. On 06/29/2026 at 10:55 AM, the MDS Coordinator explained the Director of Nursing was responsible for ensuring staff had appropriate certifications and competencies prior to being assigned PICC care. The MDS Coordinator confirmed LPN1 lacked documented IV certification and was documenting dressing changes as completed even though the dressing appeared unchanged. The facility document titled Infusion Therapy Procedures - Dressing Change for Vascular Access Devices, dated 08/2016, documented initial dressings must be changed PRN if saturated, and 24-48 hours post insertion for midlines, PICCs, or other central venous access devices if gauze or drainage was present. Transparent dressings with Biopatch may remain for seven days unless compromised. The Lippincott Manual of Nursing Practice (12th ed., 2025) documented the importance of routine and as needed IV dressing changes, including changing transparent dressings every seven days and replacing any dressing that becomes damp, loose, or soiled. The CDC document titled Summary of Recommendations: Guidelines for the Prevention of Intravascular Catheter-Related Infections, dated 02/28/2024, documented the following: -Recommendations for catheter education, training, and staffing: Educate healthcare personnel regarding the indications for intravascular catheter use, proper procedures for the insertion and maintenance of intravascular catheters, and appropriate infection control measures to prevent intravascular catheter-related infections. Designate only trained personnel who demonstrate competence for the insertion and maintenance of peripheral and central intravascular catheters. Periodically assess knowledge of and adherence to guidelines for (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all personnel involved in the insertion and maintenance of intravascular catheters.-Recommendations for catheter site dressing regimens: Replace catheter site dressing if the dressing becomes damp, loosened or visibly soiled. Replace dressing used on short-term central venous catheters (CVCs) at least every seven days for transparent dressings. Replace dressings every two days for gauze dressings. Cross reference tags F658.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure the administration of a controlled medication was documented in the controlled drug record for 1 unsampled resident (Resident #31). This deficient practice had the potential to result in inaccurate record keeping of the administration of controlled substances, misappropriation of a resident's medications and a resident's symptoms not being managed effectively. Findings include: Resident #31 Resident #31 was admitted to the facility on [DATE], with a diagnosis of quadriplegia, C1-C4 incomplete. A medication order and the May 2026 Medication Administration Record (MAR) for Resident #31 documented oxycodone hydrochloride (HCl) oral tablet 10 milligrams (mg). Give 10 mg by mouth every six hours as needed for pain management. On 06/24/2026 at 2:35 PM, during a review of the controlled drug logbook in the 100-hall medication storage cart, page 11 of the logbook documented Resident #31 had one tablet remaining of Oxycodone immediate release (IR) 10 mg. There were no corresponding bubble packs of Oxycodone matching page 11 of the logbook inside the narcotics drawer of the medication cart. The Minimum Data Set 3.0 (MDS) Coordinator verbalized all controlled substances were to be documented in the logbook and the number of the page in the logbook was written on the medication package. The MDS Coordinator searched the medication cart and confirmed the remaining tablet of Oxycodone 10 mg, as documented in the logbook, was not present in the cart. On 06/24/2026 at approximately 2:40 PM, the MDS Coordinator verbalized the MDS Coordinator reviewed Resident #31's May 2026 MAR and explained a dose of Oxycodone was administered in the morning on 05/06/2026 was not accounted for in the logbook as required. The MDS Coordinator verbalized the Director of Nursing (DON) was responsible for reviewing the narcotic logbook to ensure documentation was accurate and complete. The facility policy titled Controlled Medication Storage, dated 11/2017, documented medications included in the Drug Enforcement Administration (DEA) classification as controlled substances were subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations. The DON and the consultant pharmacist monitored for compliance with federal and state laws and regulations in the handling of controlled medications. A controlled medication accountability record was prepared when receiving inventory of schedule II medication and included the following information: name of the resident, prescription number, date received, name, strength and dosage form of the medication, quantity received and name of the person receiving the medication. Current controlled medication accountability records were kept in the MAR or narcotic book. When completed, accountability records were to be submitted to the DON and maintained on file at the nursing care center. A Department of Justice/Drug Enforcement Administration Drug Fact Sheet, dated December 2024, documented oxycodone products were schedule II narcotics under the controlled substances act.		

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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** 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 29 opportunities observed and two errors. The medication error rate was 6.9%. This deficient practice had the potential to result in residents receiving medications in a manner inconsistent with physician orders and professional standards, placing them at risk for ineffective treatment, adverse drug reactions, and compromised health outcomes. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The June 2026 Medication Administration Record (MAR) for Resident #4 documented the following: sennosides oral capsule 8.6 milligrams (mg). Give 8.6 mg by mouth one time a day for constipation - hold for loose stools give two tabs. -Zofran oral tablet 4 mg (ondansetron hydrochloride). Give 4 mg by mouth every four hours as needed for nausea. On 06/24/2026 at 9:02 AM, a Registered Nurse (RN) began preparing medication for Resident #4. The RN verbalized the scheduled medications included sennoside 8.6 mg and the medication was not available in the medication cart. The prepared medications included one scopolamine patch. On 06/24/2026 at 9:21 AM, the RN administered the prepared oral medications to Resident #4. Resident #4 declined to have the scopolamine patch administered and verbalized the resident would rather take Zofran. Resident #4's Zofran was not present in the medication cart. The RN informed Resident #4 the RN would attempt to locate additional supply of Zofran and bring it to the resident. On 06/24/2026 at 9:27 AM, the RN entered the medication storage room and attempted to access the Pyxis (an automated medication dispensing cabinet). The Pyxis was not currently functioning, and the RN was not able to access any medications inside the machine. The RN informed the Minimum Data Set 3.0 (MDS) Coordinator of the inability to access the medication. The MDS Coordinator verbalized the MDS Coordinator would attempt to restart the machine and bring the medication to the RN once the machine was working. On 06/24/2026 at 9:39 AM, after locating additional stock of sennoside 8.6 mg tablets, the RN placed one tablet in a medication cup, entered the dining room and administered the tablet to Resident #4. The RN explained to Resident #4 the Zofran was not currently available and the RN was attempting to get the medication for the resident. On 06/25/2026 at 9:10 AM, the June 2026 MAR for Resident #4 lacked documented evidence ondansetron was administered to the resident on 06/24/2026. On 06/25/2026 at 9:21 AM, the RN confirmed one tablet of sennoside 8.6 mg was administered to Resident #4 during the morning medication pass the previous day. The RN reviewed Resident #4's MAR and confirmed the instructions for the medication documented to give two tabs. The RN verbalized the RN administered the medication based on the mg listed in the instructions and had not noticed the instructions to administer two tabs. The RN verbalized the RN should have caught the discrepancy and contacted the physician to clarify the order prior to administration of the medication. The RN verbalized a dose of Zofran was administered by the RN to Resident #4 in the morning on 06/24/2026, after the Pyxis machine was restarted. The RN recalled administering the medication at approximately 10:30 AM. The RN reviewed Resident #4's MAR and confirmed the administration was not documented. On 06/25/2026 at 9:42 AM, the MDS Coordinator and the Regional Nurse Consultant (RNC) verbalized medication administration errors included not following doctor's orders, giving medications outside of the one-hour administration window, not following pharmacy recommendations and giving an incorrect dose. Documentation of medication administration was to be completed immediately after giving the medication. The RNC explained the expectation of nursing staff (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when a medication order was not clear or had conflicting information was to call the provider. The RNC and MDS Coordinator confirmed administering a medication without a clear order and/or prior to contacting the physician to clarify conflicting information in an order would be considered a medication administration error. The facility policy titled Medication Administration General Guidelines, dated 09/2018, documented medications were administered in accordance with written orders of the prescriber. If necessary, the nurse contacted the prescriber for clarification. Staff were to verify the medication was correct three times before administering the medication: when pulling the medication package from the med cart, when the dose was prepared, and before the dose was administered. The individual who administered the medication dose recorded the administration on the resident's MAR immediately following the medication being given. In no case was the individual who administered the medications to report off-duty without first recording the administration of any medications. When As Needed (PRN) medications were administered, documentation provided included date and time of administration and the signature or initials of the person recording the administration.		

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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** Based on observation, interview, and record review, the facility failed to maintain accurate and complete clinical records for 1 of 14 sampled residents (Resident #44) when the facility did not ensure bathing documentation, refusal documentation was accurately recorded and to ensure residents with indwelling urinary catheters received care and services necessary to prevent Urinary Tract Infections (UTIs) including care planning and catheter care/cleaning for 3 of 14 sampled residents (Residents #59, #5, and #18). This deficient practice had the potential to result in incomplete medical records resulting in an inaccurate representation of the residents' care needs, services provided and risks for complications related to catheter use including obstruction, UTI, and sepsis. Findings include: Resident #44 Resident #44 was admitted on [DATE], with diagnoses including need for assistance with personal care, psychosis, and major depressive disorder. On 06/22/2026 at 11:22 AM, Resident #44 verbalized not receiving scheduled showers on Sundays and Wednesdays. The resident stated scheduled showers don't happen, reported going 23 days without a shower, and stated the last shower received was on 06/21/2026. The resident described feeling dirty and crappy due to lack of bathing. Resident #44's Documentation Survey Report V2 for May 2026 lacked documentation of a shower provided or declined for the following periods: 05/03/2026 to 05/13/2026 (13 days) 05/17/2026 to 05/27/2026 (nine days) Resident #44's Care Plan dated 07/07/2025 documented the resident had an activity of daily living self-care performance deficit and required assistance with personal care. The care plan documented Resident #44 preferred showering two days per week and required one staff assistance. On 06/24/2026 at 2:40 PM, a Certified Nursing Assistant (CNA) explained residents were scheduled for showers two times per week. The CNA stated staff were responsible for offering a shower or offering an alternative if the residents declined. Staff were expected to transport the resident to the shower room and return the resident afterward. The CNA was unsure which days Resident #44 received showers. A shower aide was scheduled on 06/24/2026, but the CNA was unsure if a shower occurred. The CNA stated staff were expected to complete skin and hygiene sheets and verbalized it would not be appropriate for a resident to go more than two weeks without being offered a shower. On 06/24/2026 at 2:45 PM, a Registered Nurse (RN) stated CNAs had a daily list of assigned showers. If a resident needed assistance or refused, staff were expected to educate the resident and attempt transport to the shower room. The RN stated shower sheets were provided to nurses after bathing to identify any new skin issues and staff were required to sign and chart showers in the resident's Electronic Health Record (EHR). (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/2026 at 4:18 PM, the Infection Preventionist (IP) stated if a shower was not documented, it did not occur. The IP verbalized Resident #44 required a one-person assist in the shower and a two-person transfer from bed to chair, and the resident was dependent on staff for bathing. The IP confirmed lack of shower documentation for Resident #44 and stated it was important for the residents to receive showers for skin condition, overall health, and infection prevention. The Administrator and IP verbalized CNA documentation was incorrect. The CNAs documented resident refusals and could not be verified if Resident #44 had refused showers. The Administrator and IP stated blank entries indicated care was not provided and progress notes would need to be reviewed for accuracy. The Administrator and IP reported there was no facility-specific shower policy and staff followed CMS guidance. Cross reference tags F684. Resident #59 Resident #59 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including resistance to multiple antimicrobial drugs, urinary tract infection, and neuromuscular dysfunction of the bladder. On 06/22/2026 at 2:20 PM, Resident #59 verbalized having been in the facility since 2025, reported being hospitalized for three to four days for a severe UTI with blood in the urine, and reported having an indwelling catheter with recurring UTIs. An Order Summary Report for Resident #59 documented the following physician's orders dated 06/11/2026: -Foley Catheter size 16 (French) Balloon: 5CC change as needed (PRN) damage, occlusion, or obtaining UA. As needed for change PRN damage, occlusion, or obtaining UA. -Ertapenem Sodium Solution Reconstituted 1 gram, 1 gram intravenously every 24 hours for ESBL E Coli for 12 Days infuse 1,000 milligram (mg) into a venous catheter every 24 hours for 12 days. Resident #59's Care Plan dated 03/11/2026 documented the resident had an indwelling catheter related to neurogenic bladder and required catheter care every shift. Resident #59's Task Record lacked a scheduled task for catheter care. Resident #59's clinical record lacked documented evidence of catheter care having been provided to the resident. On 06/25/2026 at 11:28 AM, the Minimum Data Set (MDS) Coordinator reported CNAs were responsible for catheter care and cleaning, and nurses were responsible for catheter changes. The (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Coordinator explained catheter care was required every shift and CNAs documented catheter care in the resident's Electronic Medical Record (EHR) under tasks. The MDS Coordinator verbalized there was no facility policy related to catheter care and reported she was still attempting to locate documentation of catheter care for Resident #59. On 06/25/2026 at 3:44 PM, the MDS Coordinator verbalized catheter care documentation was important for monitoring outcomes and risks. The MDS Coordinator stated Resident #59 had a UTI possibly related to poor technique or lack of catheter care. The MDS Coordinator was unable to produce documentation verifying catheter care was completed for Resident #59. Missing or incomplete documentation failed to verify catheter care required by the resident's care plan was provided. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including osteomyelitis of vertebra, sacral and sacrococcygeal regionnta, diabetes mellitus 2 with neuropathy, and stage 4 pressure ulcer to sacrum. On 06/22/2026 at 9:15 AM, Resident #5 had a Foley catheter in place. The drainage bag was secured to the bed frame, and clear yellow urine was in the bag. The resident representative verbalized the resident had a Foley catheter in place and had recently recovered from a UTI. An MDS admission assessment, completed 03/20/2025, documented Resident #5 had an indwelling catheter. A Physicians Order dated 03/11/2025, documented Foley catheter 16Fr with 30cc balloon, clean Foley site every day and evening shift for skin impairment management. Resident #5's Task Record lacked a scheduled task for catheter care. Resident #5's clinical record lacked documented evidence of catheter care having been provided to the resident. On 06/24/2026 at 3:23 PM, during a review of Resident #5's care plan, the care plan Included a focus area of enhanced barrier precautions related to the catheter. The care plan for Resident #5 lacked a plan for addressing Resident #5's Foley catheter care interventions and goals. A Physicians Order dated 03/11/2026, documented Cefdinir Oral Capsule 300 milligrams give one capsule by mouth two times a day for UTI for seven days. On 06/25/2026 at 3:20 PM, the MDS Coordinator verbalized nurses and CNAs were responsible for catheter care. The MDS Coordinator explained CNAs were responsible for catheter and peri care, and nurses were responsible for changing catheters. On 06/25/2026 at 3:44 PM, the MDS Coordinator verbalized it was important for staff to document (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter care because it showed the facility was working to prevent infections. Urinary catheters were a high-risk area for infection and failure to provide catheter care placed residents at increased risk for UTI. The MDS Coordinator confirmed catheter care documentation could not be located for Resident #5. The MDS Coordinator confirmed if documentation of catheter care isn't completed, there is no guarantee catheter care was done. Resident #18 Resident #18 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, unspecified and major depressive disorder, recurrent, moderate. On 06/22/2026 at 12:04 PM, Resident #18 was lying in the resident's bed. A urinary catheter drainage bag was secured to the resident's bed frame and contained a large amount of yellow urine. The resident verbalized the catheter was recently changed by facility staff and the resident currently had a Urinary Tract Infection (UTI). An Order Summary Report for Resident #18 documented the following physician's orders: -Foley catheter size 16 (French), balloon: ten cubic centimeters (cc). Change As Needed (PRN) damage, occlusion, or obtaining urinalysis (UA). The order date was 06/04/2026. -Levaquin tablet 500 milligrams (mg). Give 500 mg by mouth one time a day for proteus mirabilis UTI for five days. The order date was 06/22/2026. Resident #18's Care Plan documented the following: -Resident #18 had a potential for infection related to indwelling catheter. Interventions included providing catheter care every shift. The date initiated was 06/04/2026. -Actual infection UTI indwelling catheter. Resident demonstrated the following signs and symptoms: new/worse urgency, frequency, suprapubic pain, and costovertebral angle tenderness. Interventions included: administer antibiotic as ordered, assist with catheter care every shift, and encourage/assist with appropriate peri-care technique. The date initiated was 06/23/2026. On 06/25/2026 at 10:41 AM, a CNA verbalized CNAs were responsible for providing catheter care for residents. If a resident had a catheter the CNA would perform catheter care at least once per day with a washcloth, soap and water. The care was documented under the tasks sections of the Electronic Medical Record (EMR). Resident #18's Task Record lacked a scheduled task for catheter care. Resident #18's clinical record lacked documented evidence of catheter care having been provided to the resident. On 06/25/2026 at 11:28 AM, the MDS Coordinator verbalized CNAs were responsible for providing (continued on next page)		

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Form Approved OMB
No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary catheter care/cleaning and nurses were responsible to change catheters when necessary. Catheter care was required to be provided every shift, and CNAs would document the care in the tasks section of the EMR. The MDS Coordinator denied the facility had a policy related to catheter care and verbalized the MDS Coordinator would attempt to find any documented evidence catheter care had been provided to Resident #18. On 06/25/2026 at 2:59 PM, the MDS Coordinator verbalized the MDS Coordinator was not able to provide any evidence catheter care had been provided to Resident #18. On 06/25/2026 at 3:44 PM, the MDS Coordinator verbalized it was important for staff to document catheter care because it showed the facility was working to prevent infections. Urinary catheters were a high-risk area for infection and failure to provide catheter care placed residents at increased risk for UTI. The Healthcare Infection Control Practices Advisory Committee's Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, updated 06/06/2019, and accessed on the Centers for Disease Control and Prevention (CDC's) website on 07/06/2026, documented proper technique for urinary catheter maintenance included but was not limited to: using standard precautions including use of gloves and gown as appropriate during any manipulation of the catheter or collection system and routine hygiene (cleansing of the meatal surface during daily bathing or showering).		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify the facility lacked a process to ensure residents were screened for eligibility to receive an influenza and/or pneumococcal vaccine upon admit and annually thereafter. This deficient practice resulted in a substandard quality of care related to the facility's immunization program. Findings include: On 06/29/2026 at 3:03 PM, the Administrator confirmed the QAPI committee had not identified a concern related to screening residents for eligibility to receive influenza and/or pneumococcal vaccines at admit and annually thereafter. The Administrator explained the Administrator was not sure how the QAPI committee could have identified the concern and verbalized identifying the concern could have led to a change in the immunization process by adding a document with targeted questions. The facility policy titled QAPI Plan updated and approved 02/06/2026, documented QAPI was a dynamic process used to facilitate the identification of areas for improvement and to drive quality of care and services. The QAPI committee was tasked with identifying areas requiring performance improvement, collecting data, developing and implementing corrective action, and creating monitors to determine and validate changes were effective and sustained. Cross reference with tag F883		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview, personnel record review, and document review, the facility failed to ensure initial and annual communication training was completed timely per facility policy for 8 of 20 sampled employees (Employee #4, #10, #11, #12, #13, #15, #16 and #17). This deficient practice had the potential to prevent residents with communication needs from attaining or maintaining their highest practicable physical, mental and psychosocial well-being. Findings include:Employee #4 Employee #4 was hired as the Registered Dietician on 12/08/2025. Employee #4's personnel record documented Communication Training completed on 05/13/2025; however, lacked annual training completed for 2026. Employee #10 Employee #10 was hired as a CNA hired on 01/16/2026. Employee #10's personnel record lacked documented evidence of Communication Training completed upon hire. Employee #11 Employee #11 was hired as a Speech Pathologist on 02/03/2026. Employee #11's personnel record lacked documented evidence of Communication Training completed upon hire. Employee #12 Employee #12 was hired as the Infection Preventionist on 03/11/2026. Employee #12's personnel record lacked documented evidence of Communication Training completed upon hire. Employee #13 Employee #13 was hired as a Registered Nurse on 01/13/2026. Employee #13's personnel record lacked documented evidence of Communication Training completed upon hire. Employee #15 Employee #15 was hired as a Licensed Practical Nurse hired on 01/26/2026. Employee #15's personnel record lacked documented evidence of Communication Training completed upon hire. Employee #16 Employee #16 was hired as a Certified Nursing Assistant (CNA) hired on 04/23/2026. Employee #16's personnel record lacked documented evidence of Communication Training completed upon hire. Employee #17 Employee #17 was hired as a CNA hired on 11/28/2025. Employee #17's personnel record lacked documented evidence of Communication Training completed upon hire. On 06/29/2026 at 8:43 AM, the Business Office Manager (BOM) explained there was orientation training upon hire and annual training thereafter. The agency staff do not go directly through the facility for orientation training. The BOM confirmed Employee #4, #10, #11, #12, #13, #15, #16 and #17 personnel record lacked documented evidence of Communication training completed upon hire and annually. The facility policy titled, Nursing Personnel Education and Training, published 11/2016, documented education provided for new employees and contract staff provided as part of orientation and scheduled annually, includes Communication Training.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview, personnel record review, and document review, the facility failed to ensure initial Quality Assurance and Performance Improvement (QAPI) training was completed timely per facility policy for 5 of 20 sampled employees (Employee #9, #10, #15, #16 and #17). This deficient practice had the potential to put residents at risk of receiving care from employees unaware of facility regulations. Findings include: Employee #9 Employee #9 was hired as a Certified Nursing Assistant (CNA) hired on 08/05/2020. Employee #9's personnel record documented QAPI training completed on 09/16/2024, however, lacked documented evidence of annual QAPI training completed in 2025. Employee #10 Employee #10 was hired as a CNA hired on 01/16/2026. Employee #10's personnel record lacked documented evidence of QAPI training completed upon hire. Employee #15 Employee #15 was hired as a Licensed Practical Nurse hired on 01/26/2026. Employee #15's personnel record lacked documented evidence of QAPI training completed upon hire. Employee #16 Employee #16 was hired as a CNA hired on 04/23/2026. Employee #16's personnel record lacked documented evidence of QAPI training completed upon hire. Employee #17 Employee #17 was hired as a Certified Nursing Assistant hired on 11/28/2025. Employee #17's personnel record lacked documented evidence of QAPI training completed upon hire. On 06/29/2026 at 8:43 AM, the Business Office Manager (BOM) explained there was orientation training upon hire and annual training thereafter. The agency staff do not go directly through the facility for orientation training. The BOM confirmed Employee #9, #10, #15, #16 and #17's personnel record lacked documented evidence of QAPI training completed upon hire and annually. The facility policy titled, Nursing Personnel Education and Training, published 11/2016, documented education provided for new employees and contract staff provided as part of orientation and scheduled annually, includes Quality Assurance Program.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interview, personnel record review, and document review, the facility failed to ensure initial and annual infection control training was completed timely per facility policy for 3 of 20 sampled employees (Employee #9, #15 and #16). This deficient practice had the potential to put residents at risk of contracting avoidable infections and diseases. Findings include:Employee #9 Employee #9 was hired as a Certified Nursing Assistant (CNA) hired on 08/05/2020. Employee #9's personnel record documented Infection Control training completed on 09/23/2024, however, lacked documented evidence of annual QAPI training completed in 2025. Employee #15 Employee #15 was hired as a Licensed Practical Nurse hired on 01/26/2026. Employee #15's personnel record lacked documented evidence of Infection Control training completed upon hire. Employee #16 Employee #16 was hired as a CNA hired on 04/23/2026. Employee #16's personnel record lacked documented evidence of Infection Control training completed upon hire. On 06/29/2026 at 8:43 AM, the Business Office Manager (BOM) explained there was orientation training upon hire and annual training thereafter. The agency staff do not go directly through the facility for orientation training. The BOM confirmed Employee #9, #15 and #16's personnel record lacked documented evidence of Infection Control training completed upon hire and annually. The facility policy titled, Nursing Personnel Education and Training, published 11/2016, documented education provided for new employees and contract staff provided as part of orientation and scheduled annually, includes Infection Control Training.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on interview, personnel record review, and document review, the facility failed to ensure initial and annual compliance and ethics training was completed timely per facility policy for 3 of 20 sampled employees (Employee #2, #9 and #16). This deficient practice had the potential to put residents at risk of receiving care from employees unaware of facility regulations. Findings include:Employee #2 Employee #2 was hired as the Director of Nursing on 07/29/2024. Employee #2's personnel record documented compliance and ethics training completed on 04/01/2025; however, lacked annual training completed for 2026. Employee #9 Employee #9 was hired as a Certified Nursing Assistant hired on 08/05/2020. Employee #9's personnel record documented compliance and ethics training completed on 05/02/2025; however, lacked annual training completed for 2026. Employee #16 Employee #16 was hired as a Certified Nursing Assistant hired on 04/23/2026. Employee #16's personnel record lacked documented evidence of initial compliance and ethics training. On 06/29/2026 at 8:43 AM, the Business Office Manager (BOM) explained there was orientation training upon hire and annual training thereafter. The agency staff do not go directly through the facility for orientation training. The BOM confirmed Employee #2, #9 and #16's personnel record lacked documented evidence of Compliance and Ethics training completed upon hire and annually. The facility policy titled, Nursing Personnel Education and Training, published 11/2016, documented education provided for new employees and contract staff provided as part of orientation and scheduled annually, includes Compliance and Ethics Training.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER Gardnerville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1573 South Muller Pkwy Gardnerville, NV 89410	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview, personnel record review, and document review, the facility failed to ensure initial and annual Behavioral Health training was completed timely per facility policy for 15 of 20 sampled employees (Employee #1, #2, #3, #5, #6, #7, #8, #9, #10, #12, #13, #14, #15, #16, and #17). This deficient practice had the potential to put residents at risk of receiving care from employees unaware of facility regulations. Findings include: Employee #1 Employee #1 was hired as the Administrator on 07/16/2025. Employee #1's personnel record lacked documented evidence of initial behavioral health training. Employee #2 Employee #2 was hired as the Director of Nursing on 07/29/2024. Employee #2's personnel record lacked documented evidence of annual behavioral health training. Employee #3 Employee #3 was hired as the Activities Director on 03/04/2019. Employee #3's personnel record lacked documented evidence of annual behavioral health training. Employee #5 Employee #5 was hired as a Social Worker on 07/11/2022. Employee #5's personnel record lacked documented evidence of annual behavioral health training. Employee #6 Employee #6 was hired as the Dietary Manager on 04/12/2022. Employee #6's personnel record lacked documented evidence of annual behavioral health training. Employee #7 Employee #7 was hired as a Certified Nursing Assistant (CNA) on 04/17/2025. Employee #7's personnel record lacked documented evidence of annual behavioral health training. Employee #8 Employee #8 was hired as a CNA on 04/17/2025. Employee #8's personnel record lacked documented evidence of annual behavioral health training. Employee #9 Employee #9 was hired as a CNA on 08/05/2020. Employee #9's personnel record lacked documented evidence of annual behavioral health training. Employee #10 Employee #10 was hired as a CNA on 01/16/2026. Employee #10's personnel record lacked documented evidence of annual behavioral health training. Employee #12 Employee #12 was hired as the Infection Preventionist on 03/11/2026. Employee #12's personnel record lacked documented evidence of initial behavioral health training. Employee #13 Employee #13 was hired as the Registered Nurse on 01/13/2026. Employee #13's personnel record lacked documented evidence of initial behavioral health training. Employee #14 Employee #14 was hired as the Licensed Practical Nurse on 08/28/2025. Employee #14's personnel record lacked documented evidence of initial behavioral health training. Employee #15 Employee #15 was hired as the Licensed Practical Nurse on 01/26/2026. Employee #15's personnel record lacked documented evidence of initial behavioral health training. Employee #16 Employee #16 was hired as the CNA on 01/26/2026. Employee #16's personnel record lacked documented evidence of initial behavioral health training. Employee #17 Employee #17 was hired as the CNA on 11/28/2025. Employee #17's personnel record lacked documented evidence of initial behavioral health training. On 06/29/2026 at 8:43 AM, the Business Office Manager (BOM) explained there was orientation training upon hire and annual training thereafter. The agency staff do not go directly through the facility for orientation training. The BOM confirmed Employee #1, #2, #3, #5, #6, #7, #8, #9, #10, #12, #13, #14, #15, #16, and #17's personnel record lacked documented evidence of Behavioral Health training completed upon hire and annually. The facility policy titled, Nursing Personnel Education and Training, published 11/2016, documented education provided for new employees and contract staff provided as part of orientation and scheduled annually, includes Behavioral Health training.		