

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Highland Manor of Fallon		STREET ADDRESS, CITY, STATE, ZIP CODE 550 North Sherman Street Fallon, NV 89406	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40377</p> <p>Based on observation, interview, and document review, the facility failed to ensure a resident's dignity was maintained when an employee was standing over the residents while providing feeding assistance for 3 of 3 residents requiring assistance with eating in the 200 unit dining room.</p> <p>Findings include:</p> <p>On 04/30/2024 at 12:35 PM, a Certified Nursing Assistant (CNA) was observed assisting three residents with the lunch meal service at the same table while standing over all three residents. The CNA picked up silverware wrapped in a napkin off the first resident's lap and proceeded to use the knife and fork to cut up the resident's meal, assisting them with eating. While the resident was chewing, the CNA moved to a second resident and assisted the resident with eating their meal using their fork. The CNA did not use an alcohol-based hand sanitizer (ABHS) between assisting the first and second resident. The CNA then moved to help a third resident eat their meal using a spoon and a scoop plate, without using ABHS between the second and third residents. The CNA did not sit down with any of the three residents while assisting them with eating. The CNA stood the entire time.</p> <p>On 04/30/2024 at 2:29 PM, the CNA verbalized the process of providing feeding assistance to a resident involved assisting the resident cut up their food and feeding the resident slowly and allowing the resident time to chew. The CNA did not know how many residents could be assisted at one time and verbalized the CNA had always assisted more than one resident since employed at the facility.</p> <p>On 04/30/2024 at 5:19 PM, the Assistant Director of Nursing (ADON), confirmed the CNAs received feeding assistance training during their certification program and during their onboarding at the facility. The ADON verbalized the staff providing feeding assistance to a resident need to sit down with the resident, let the resident know what they are doing and ask the resident their preferences with what food they want to eat. The ADON verbalized a staff member can technically sit between two residents and assist both but would need to sanitize their hands between helping each resident.</p> <p>The facility policy titled Feeding Assistance, last revised 02/2004, lacked documented evidence in the procedure to address a staff member feeding the resident was required to sit or the maximum number of residents a staff member can assist at one time.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Resident Rights, last revised 11/28/2017, documented the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310</p> <p>Based on observation, clinical record review, interview, and document review, the facility neglected to ensure a resident was properly secured for transport in the facility's transport bus resulting in fall with injury for 1 of 24 sampled residents (Resident #11) and failed to ensure two residents were protected from resident-to-resident verbal and physical abuse for 2 of 24 sampled residents (Resident #12 and #13).</p> <p>Findings include:</p> <p>Fall</p> <p>Resident #11</p> <p>Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, Parkinson's disease, type II diabetes mellitus with diabetic nephropathy, unspecified, osteoarthritis, unspecified site, other specified disorders of bone density and structure, unspecified site, pain in right knee, muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, and muscle weakness.</p> <p>A facility document titled Event Report, dated 12/05/2023, documented Resident #11 had a witnessed fall from the resident's wheelchair while on the transport bus. The bus hit a curb and Resident #11 lost balance in the resident's wheelchair. There were two staff members present. Resident #11 complained of neck and back pain and rated the pain as five out of ten on a numeric scale of 0-10. Injuries included a head bump, abrasions, bruising, redness, swelling, laceration, and skin tear. The wheelchair was strapped to the floor of the bus. The resident was sent from the scene of the accident to an acute care hospital for evaluation and treatment.</p> <p>A Nurse Progress note dated 12/05/2023, documented a Certified Nursing Assistant (CNA) verbalized to a Licensed Practical Nurse (LPN), Resident #11 was being transported back to the facility on the facility bus when the bus struck a curb and Resident #11 slid out of the resident's chair and was lying on the floor of the bus and out of the resident's Hoyer sling. Resident #11 was awake and alert, complained of head and neck pain, and had several scrapes on the resident's arms. Two staff members drove from the facility to the bus and assisted in getting the resident up and into the resident's wheelchair. The resident was transported to an acute care emergency room (ER).</p> <p>A Nurse Progress note dated 12/06/2023, documented Resident #11 was transported back to the facility by Emergency Medical Services (EMS) on 12/06/23. Resident #11 had bruising to the left forehead and left arm, a bump on the top of the head and mid forehead. There was a splint on the resident's right leg. Diagnoses included a right tibial fracture and closed head trauma.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurse Progress note dated 12/07/2023 (late entry), written by the Director of Nursing (DON), documented on 12/06/2023, Resident #11 had a witnessed fall out of a wheelchair during a return transport from a medical appointment. Resident #11 was placed in the transport bus and the wheelchair was secured, but the resident was not secured with a lap belt. The resident fell from the wheelchair and sustained a hematoma to the forehead, complained of neck and head discomfort. Resident #11 was taken to the ER.</p> <p>An Investigation Note dated 12/12/2023, documented the following:</p> <p>-On 12/05/2023 Resident #11 had a witnessed fall from a wheelchair while being transported on the facility's transportation bus. Resident #11 was placed in the facility van (bus), the wheelchair was secured, but a lap belt was not placed on the resident. The resident leaned forward and fell from the wheelchair when the transport bus came to a stop. The resident recalled being in the resident's wheelchair and on the transport bus when the bus stopped and the resident leaned forward and just kept going and hit the resident's head. The resident continued to have head and neck pain. Resident #11 explained when transferred back to the resident's wheelchair, the resident's foot caught on something and was injured. The injury occurred after the fall while being transported to the ER.</p> <p>-A report including imaging results was received from the hospital and included findings of severe degenerative disease but no fracture to the head or neck. Resident #11 had a right tibia ankle fracture.</p> <p>-On 12/11/2023, Resident #11 was transported to a hospital for a scheduled sleep study, during the appointment, the resident complained of feeling ill and was transferred to an ER. A Computed Topography (CT) scan was completed, and it was determined that Resident #11 had a C-1 (cervical) vertebrae fracture.</p> <p>-Resident #11 continued to complain of pain following the fall on 12/05/2023, with no change in the level of pain.</p> <p>-Exhaustive interviews were conducted and no other trauma to the resident's head and neck were found. The resident's baseline level of activity was bed bound and the resident had remained bed bound with the exception of medical appointments.</p> <p>-After thorough investigation it was determined to be likely the fracture occurred when Resident #11 fell on [DATE].</p> <p>On 04/30/24 at 3:23 PM, the Director of Maintenance (DM) verbalized the Maintenance Department was responsible for oversight of transportation. The DM verbalized training for transportation included how to harness/secure each corner of a wheelchair and to apply a seat belt for the resident. The DM believed training was previously provided in April or May 2023, but the DM was not responsible for oversight of the Transportation Department at the time and was not sure when training was provided.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 3:26 PM, the DM recalled Resident #11 was transported to a healthcare facility in the facility transport bus. The bus hit a dip in the parking lot of the healthcare facility. The bus rocked back and forth, and Resident #11 fell from the resident's wheelchair. A CNA and an additional transport staff member were sent to assist with getting the resident up. After the resident was back up and in the resident's wheelchair, the resident was being helped out of the bus. To exit the bus the wheelchair was placed on a lowering platform (lift) to be lowered from the bus. The lift had a gate which remained in an upward position while the lift was moving to ensure the wheelchair would not roll from the lift while it was in motion. The gate would fold out flat when the gate came in contact with the ground so the wheelchair could exit the platform. The DM explained Resident #11 was placed on the lift facing forward. Resident #11's foot was sticking out and when the gate was activated it hit the resident's right foot.</p> <p>On 04/30/24 at 3:33 PM, the DM explained the correct way to place the wheelchair on the platform was to have the back of the wheelchair facing the gate of the lift. The purpose of the lift gate was to stop the wheelchair from rolling by stopping the back tires, rather than the front tires. Lifts did not include straps to hold a wheelchair in place. Staff were supposed to hold the wheelchair in place while the lift was being lowered. The DM confirmed Resident #11 was not correctly placed on the lift and placing the resident with the back of the wheelchair towards the gate would have prevented the injury (ankle fracture) from occurring.</p> <p>On 04/30/2024 at 4:12 PM, the Assistant Director of Nursing (ADON) verbalized a lap belt was not applied when Resident #11 was being transported in the facility's transport bus on 12/05/23. The ADON confirmed wearing a lap belt may have prevented Resident #11 from falling and being injured on the transport bus.</p> <p>43311</p> <p>Verbal and Physical Abuse</p> <p>Resident #12</p> <p>Resident #12 was admitted to the facility on [DATE], with diagnoses including other cerebral palsy, violent behavior, and other mixed anxiety disorders.</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including unspecified dementia, severe, with other behavioral disturbance, and violent behavior.</p> <p>FRI #NV00070711 documented on 03/17/2024, an Activity Assistant witnessed Resident #12 and Resident #1 yelling at each other in the hallway outside of the Activities room. Resident #1 was heard to say they almost scratched Resident #12's eyes out. Resident #12 reported Resident #1 had struck Resident #12. Resident #12 was assessed by a nurse and found to have two scratches on the forehead.</p> <p>A Nursing Progress Note dated 03/17/2024, documented Resident #1 was witnessed by staff to have a physical altercation with Resident #12. Resident #12 had two scratch marks on the forehead that were cleaned and left open to air.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nursing Progress Note dated 03/18/2024, documented Resident #12 had no adverse effects noted to physical altercation with other resident. 1.5 centimeter (cm) by 2 cm abrasion noted to forehead, area cleansed and left open to air.</p> <p>On 04/30/2024 at 1:34 PM, a CNA explained Resident #1 liked to threaten to beat people up and often had to separate Resident #1 from other residents for the behavior.</p> <p>On 04/30/2024 at 2:21 PM, the Assistant Director of Nursing (ADON) confirmed the altercation occurred between Resident #1 and Resident #12 and was initiated by Resident #1.</p> <p>On 04/30/2024 at 3:07 PM, the ADON defined abuse as verbal, physical actions that make someone else feel uncomfortable, especially if the person feels discomfort on an ongoing basis.</p> <p>Resident #13</p> <p>Resident #13 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to embolism of cerebral artery and vascular dementia with other behavioral disturbance.</p> <p>FRI #NV00070776 documented on 03/24/2024, Resident #1 had verbally abused and cursed at Resident #13. Resident #13 yelled back at Resident #1 and Resident #1 then hit Resident #13 with a closed fist.</p> <p>A Nursing Progress Note dated 03/24/2024, documented Resident #1's provider had been informed of the resident's behavioral event and Resident #1's unpredictable, escalating, and hostile behaviors. Place resident on arm's length when in activities, outside smoking, or in large groups of residents.</p> <p>A Nursing Progress Note dated 03/24/2024, documented Resident #1 and Resident #13 had been waiting in line to sign out for a smoking break. Resident #13 was in line to go first when Resident #1 called Resident #13 names and tried to get in front of the line. Resident #1 struck out with a closed fist and contacted Resident #13 on the left shoulder blade area. The residents were then separated. Staff to be within arm's length when Resident #1 was out smoking.</p> <p>A Nursing Progress Note dated 03/25/2024, documented Resident #1 had been accepted to a local psychiatric facility for evaluation.</p> <p>On 04/30/2024 at 3:48 PM, the Social Services Director (SSD) confirmed Resident #1 had a verbal and physical altercation with Resident #13 on 03/24/2024. The SSD explained Resident #1 had used a balled-up fist to strike Resident #13 on the back left shoulder blade. The SSD confirmed Resident #1 was admitted to a local psychiatric hospital on 03/25/2024.</p> <p>On 04/30/2024 at 5:17 PM, the Administrator defined abuse as causing harm or intending harm to an individual.</p> <p>The facility policy titled Abuse Prohibition and Reporting (Elder Justice Act), revised 07/13/2023, documented the policy purpose was to protect residents from any kind of abuse such as verbal, sexual, mental, and physical and would comply with related reporting requirements under Federal and State regulations. If another resident in the facility was the perpetrator of the abuse, the Administrator/designee would take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator could be evaluated.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>30748</p> <p>Based on interview, clinical record review , and document review, the facility failed to ensure reports of suspected abuse toward residents were submitted to the Ombudsman's office from January 2024 through April 2024 for 9 of 19 Facility Reported Incidents (FRI) investigated, and the final FRI investigation was submitted to the State Agency timely for 5 of 19 FRIs investigated. The deficient practice could result in inquiries of abuse not being investigated, allowing potential abuse to occur without being reported to the Ombudsman's office, the State Agency, and /or Law Enforcement.</p> <p>Findings include:</p> <p>FRI #NV00070519 dated 02/21/2024, documented Resident #8 became verbally abusive and agitated when a Certified Nursing Assistant (CNA) was assisting Resident #9 with cares during the night.The FRI lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>FRI #NV00070713 dated 03/17/2024, documented Resident #9 and Resident #10 were outside smoking a cigarette together. Resident #9 claimed Resident #10 was calling the resident names in Resident #10's mind and Resident #9 could hear the thoughts. Resident #9 became upset and called Resident #10 names in response. The FRI lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>40377</p> <p>FRI #NV00070523 with an allegation of Resident #2 yelling at Resident #3 for interrupting Resident #2 with a Caregiver in the activity room prior to a smoking break was submitted to the State Agency (SA) on 02/21/2024 at 6:04 PM. A final investigation report was submitted on 02/27/2024 at 9:49 PM, to the SA, one day late. The FRI lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>FRI #NV00070782 with an allegation of Resident #1 reaching out and making contact with Resident #3 after Resident #3's wheelchair accidentally bumped Resident #2's wheelchair in a designated smoking area lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>46301</p> <p>FRI #NV00070242 with an allegation of Resident #18 inappropriately touched Resident #19's thigh while sitting at the dining room table lacked documented evidence of reporting to the State Ombudsman's Office</p> <p>43311</p> <p>FRI #NV00071009 with an allegation Resident #14 was kicked at by Resident #15 was submitted to the SA on 04/22/2024. A final FRI report was not submitted as of the date of survey. The FRI lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>FRI #NV00070711 with an allegation Resident #12 and Resident #1 were in a verbal and physical altercation was submitted to the SA on 03/17/2024. A final FRI report was submitted on 03/23/2024, two days late. The FRI lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>FRI #NV00070776 with an allegation Resident #1 yelled at and struck Resident #13 on the rear left shoulder blade while signing out for a smoking break was submitted to the SA on 03/24/2024. A final FRI report was submitted to the State Agency on 03/29/2024, one day late. The FRI lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>49557</p> <p>FRI#NV00070388 dated 02/03/2024, documented Resident #22 and Resident #21 had a physical resident-to-resident altercation lacked documented evidence of reporting to the State Ombudsman's Office.</p> <p>FRI#NV00070549 dated 02/23/2024, documented Resident #18 became physically aggressive with Resident #16 in the dining area when Resident #16 was seated in the spot Resident #18 usually sat lacked documented evidence of reporting to the State Ombudsman's Office. The final FRI report was submitted 04/26/2024.</p> <p>On 04/30/2024 at 3:58 PM, the Administrator verbalized final FRI reports were to be reported to the SA within 5 days of the alleged abuse. The Administrator confirmed final FRI reports submitted to the SA 6 days or more following the incident were considered late.</p> <p>The Administrator verbalized allegations of abuse should be reported to the Ombudsman. The Administrator explained allegations of abuse toward residents had not been reported to the Ombudsman from 01/2024 to 04/2024.</p> <p>The facility policy titled Abuse Prohibition and Reporting, revised 07/13/2023, documented if an allegation involved abuse, the allegation would be reported immediately (no later than two hours after the allegation was made) to the SA and the Ombudsman. The Administrator or designee was responsible for supervising the investigation and reporting the final results of the investigation to the SA within five working days of the initial report. The Administrator would keep copies of all notes from conducted interviews by the Administrator or other facility interviewer in the course of the investigation. The results of the investigation would also be sent to the Ombudsman.</p> <p>The facility policy titled Abuse Investigation Checklist, revised 07/2023, documented the administrator or designee was responsible for filing the final report with the Division of Public and Behavioral Health within five working days of the occurrence. The administrator or designee would also notify the resident and resident's representative of the results of the investigation.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on interview, clinical record review, and document review the facility failed to thoroughly investigate allegations of abuse and lacked documented evidence of the abuse investigations for 1 of 25 sampled residents (Resident #23).</p> <p>Findings include:</p> <p>Resident #23</p> <p>Resident #23 was admitted to the facility on [DATE], with diagnoses including fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing (primary) and chronic obstructive pulmonary disease, unspecified.</p> <p>An initial FRI dated 12/14/2023, documented an allegation of employee-to-resident abuse involving the Director of Rehab (DOR) and Resident #23.</p> <p>A progress note dated 12/14/2023, documented the Director of Nursing (DON) met with Resident #23. Resident #23 expressed concerns related to a staff member. The DON informed the abuse coordinator of Resident #23's concerns and the abuse coordinator was conducting an investigation.</p> <p>On 04/30/2024 at 2:51 PM, the DOR recalled the DOR was informed of allegations of abuse made against the DOR however, the DOR was not informed which resident made the allegations. The DOR was escorted off the facility property and suspended until an investigation was complete. The DOR verbalized The DOR was asked to send email with a recollection of all events on 12/14/2023. The DOR verbalized the DOR was never interviewed face-to-face or via phone. The DOR was notified the allegations of abuse were unsubstantiated based on the facility's investigation and the DOR was released back to work.</p> <p>On 04/30/2024 at 3:09 PM, the Administrator verbalized the alleged abuse toward Resident #23 on 12/14/2023, occurred prior to the current Administrator beginning employment at the facility. The Administrator provided all documents the facility had related to the facility's investigation into the abuse allegations. The documents included a copy of the initial FRI report, a copy of the final FRI report, and a copy of an interview conducted with the resident.</p> <p>On 04/30/2024 at 3:58 PM, the Administrator verbalized the process when an allegation of employee-to-resident abuse was made was to first escort the employee off facility property and complete an investigation. The investigation included talking to residents and any staff who may have been in the area where the alleged incident occurred. The Administrator confirmed the facility lacked any other documentation related to the investigation into the allegations of abuse involving Resident #23 and the DOR.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Abuse Prohibition and Reporting, revised 07/13/2023, documented investigation into allegations of abuse included interviews with all involved parties or potential witnesses. Statements should be taken from the suspect and the person making the accusations, the resident abused, other staff or residents who may have witnessed the incident and any other person who may have information related to the incident. The Administrator shall keep copies of all notes from the interviews conducted.</p> <p>FRI #NV00070035</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311</p> <p>Based on interview, clinical record review and document review, the facility failed to update a Care Plan after 1) a resident to resident altercation for 11 of 25 sampled residents (Resident #12, #13, #14, #15, #16, #18, #19, #20, #21, #22 and #3) and 2) an allegation of employee to resident abuse for 1 of 25 sampled residents (Resident #23).</p> <p>Findings include:</p> <p>Resident #12</p> <p>Resident #12 was admitted to the facility on [DATE], with diagnoses including other cerebral palsy, violent behavior, and other mixed anxiety disorders.</p> <p>The Care Plan for Resident #12 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE].</p> <p>On [DATE] at 3:30 PM, the Assistant Director of Nursing (ADON) confirmed Resident #12's Care Plan was not updated after the resident-to-resident altercation occurring on [DATE].</p> <p>FRI #NV00070711</p> <p>Resident #13</p> <p>Resident #13 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to embolism of cerebral artery and vascular dementia with other behavioral disturbance.</p> <p>The Care Plan for Resident #13 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE].</p> <p>FRI #NV00070776</p> <p>Resident #14</p> <p>Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavior and other symptoms and signs with cognitive functions and awareness.</p> <p>The Care Plan for Resident #14 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE].</p> <p>Resident #15</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highland Manor of Fallon		STREET ADDRESS, CITY, STATE, ZIP CODE 550 North Sherman Street Fallon, NV 89406	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #15 was admitted to the facility on [DATE], with diagnoses including dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance and cognitive communication deficit.</p> <p>The Care Plan for Resident #15 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE].</p> <p>FRI #NV00071009</p> <p>On [DATE] at 3:07 PM, the ADON confirmed Resident #14 and Resident #15 did not have an updated care plan related to the resident-to-resident altercation on [DATE].</p> <p>On [DATE] at 3:44 PM, the Social Services Supervisor explained the facility would update a care plan for specific behaviors but did not update the care plan with specific incidents or dates.</p> <p>On [DATE] at 3:59 PM, the Administrator verbalized the expectation was the resident care plans would be updated to reflect a resident-to-resident altercation and was specific to the incident and date.</p> <p>46301</p> <p>Resident #16</p> <p>Resident #16 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, moderate psychotic disturbance, major depressive disorder, and anxiety disorder.</p> <p>The Care Plan for Resident #16 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE] and [DATE].</p> <p>FRI #NV00070060, FRI #NV00070549</p> <p>Resident #18</p> <p>Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, with other behavioral disturbance, generalized epilepsy and major depressive disorder.</p> <p>The Care Plan for Resident #18 lacked documented evidence the care plan was updated after resident-to-resident incident occurring on [DATE].</p> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease, depression and bipolar disorder. Resident expired on [DATE].</p> <p>The Care Plan for Resident #19 lacked documented evidence the care plan was updated after resident-to-resident incident occurring on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 5:36 PM, the Administrator confirmed Resident #19's Care Plan was not updated after the resident-to-resident incident occurring on [DATE].</p> <p>FRI #NV00070242</p> <p>Resident #20</p> <p>Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dementia with other behavioral disturbances, depression, and generalized anxiety.</p> <p>The Care Plan for Resident #20 lacked documented evidence the care plan was updated after a resident-to-resident incident occurring on [DATE].</p> <p>On [DATE] at 5:36 PM, the Administrator confirmed Resident #20's Care Plan was not updated after the resident-to-resident incident occurring on [DATE].</p> <p>FRI #NV00069542</p> <p>40377</p> <p>Resident #3</p> <p>Resident #3 , was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, unspecified (Primary), major depressive disorder, recurrent, severe with psychotic symptoms, major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified, other symptoms and signs involving cognitive functions and awareness, and insomnia, unspecified.</p> <p>The Care Plan for Resident #3 lacked documented evidence the resident's comprehensive care plan was updated after a resident to resident altercation occurring on [DATE] and [DATE].</p> <p>On [DATE] at 2:37 PM, the ADON verbalized when there was an altercation between residents, the resident's care plan would be updated to reflect a behavior problem, if not already identified, and documentation of the incident and new approaches developed to remediate future incidents. The ADON confirmed Resident #3's care plan was not updated for the incidents of [DATE] and [DATE].</p> <p>FRI #NV00069946 and #NV00070075</p> <p>49557</p> <p>Resident #21</p> <p>Resident #21 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, severe, with anxiety and other symptoms and signs involving cognitive functions and awareness.</p> <p>The Care Plan for Resident #21 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>FRI #NV00070388</p> <p>Resident #22</p> <p>Resident #22 was admitted to the facility on [DATE], with diagnoses including dementia in other diseases classified elsewhere, mild, with other behavioral disturbance and circadian rhythm sleep disorder, unspecified type.</p> <p>The Care Plan for Resident #22 lacked documented evidence the care plan was updated after a resident-to-resident altercation occurring on [DATE].</p> <p>FRI #NV00070388</p> <p>Employee-to-Resident</p> <p>Resident #23</p> <p>Resident #23 was admitted to the facility on [DATE], with diagnoses including fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing (primary) and chronic obstructive pulmonary disease, unspecified.</p> <p>The Care Plan for Resident #23 lacked documented evidence the care plan was updated after an allegation of employee-to-resident abuse was made on [DATE].</p> <p>FRI #NV00070035</p> <p>On [DATE] at 3:58 PM, the Administrator verbalized the expectation of documentation following allegations of resident to resident or staff to resident abuse included progress notes from nurses and updates to care plans. Updates to care plans would include and be specific to the incident or allegation.</p> <p>The facility policy titled Care Plan, last revised [DATE], documented the comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and the resident's goals for admission, desired outcomes, and preferences for future discharge.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>41848</p> <p>Based on interview and document review, the facility failed to ensure there were eight hours of consecutive Registered Nurse (RN) coverage for 1 of 30 days reviewed for staffing and the facility had a full time Director of Nursing (DON). This deficient practice could have allowed all 77 residents residing in the facility on the affected date to go without proper assessments or certain cares RNs can perform and compromise the supervision of nursing care due to lack of oversight.</p> <p>Findings include:</p> <p>RN Coverage</p> <p>Review of the facility nursing schedules, Staffing Report posting, and RN Timecard Reports for the date of 04/28/2024 revealed the following:</p> <ul style="list-style-type: none"> - RN1 worked from 5:41 PM until Midnight for a consecutive total of six hours and 19 minutes. - RN2 worked from 6:00 PM until Midnight for a consecutive total of six hours. <p>On 04/30/2024 at 1:56 PM, the Administrator verbalized RN1 and RN2 were the only RNs who had worked in the facility on 04/28/2024. The Administrator confirmed the facility did not meet the requirement for eight consecutive hours of RN coverage on 04/28/2024.</p> <p>Full Time DON</p> <p>The staffing list provided by the facility on 04/30/2024, did not include a DON.</p> <p>On 04/30/2024 at 3:14 PM, the Administrator verbalized the facility did not have a DON. The DON resigned on 04/18/2024, and the position had not yet been filled. The Administrator confirmed the facility was required to have full-time DON coverage.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40377</p> <p>Based on observation, interview, and document review, the facility failed to 1) ensure staff used appropriate hand hygiene when working in the kitchen and serving resident food items, and 2) ensure staff used appropriate hand hygiene when providing feeding assistance to residents. The deficient practice could impact the sanitary conditions of the working area for preparing resident food and meals and the potential to cause the spread of food borne illness to residents in the facility.</p> <p>Findings include:</p> <p>On 04/30/2024 at 12:15 PM, Certified Nursing Assistant (CNA1) entered the kitchen in Unit 200 to retrieve a tray of drinks and deserts from the refrigerator. CNA1 did not use the sink in the kitchen to perform hand hygiene prior to retrieving the food items from the refrigerator.</p> <p>On 04/30/2024 at 12:17 PM, CNA1 removed gloves from a box of gloves hanging on the wall. CNA1 dropped one of the gloves on the floor and retrieved the glove. CNA1 did not dispose of the glove and donned both gloves then picked up the tray of drinks from the refrigerator and distributed the drinks to the residents sitting in the dining room.</p> <p>On 04/30/2024 at 12:19 PM, CNA1 verbalized CNA1 had performed hand hygiene after providing resident care and prior to starting service in the dining room.</p> <p>On 04/30/2024 at 12:20 PM, CNA1 retrieved a set of gloves from CNA1's scrubs pocket and donned the gloves then served the residents their plated lunch meal.</p> <p>On 04/30/2024, CNA2 provided feeding assistance to three residents sitting at the same table in the Unit 200 dining room. CNA2 did not use an alcohol based hand sanitizer between assisting each resident, before making contact with the resident or the resident's utensils.</p> <p>On 04/30/2024 at 2:29 PM, CNA2 verbalized CNA2 received training for feeding assistance during CNA2's certification program and CNA2's feeding assistance competencies were verified during the facility's onboard process as an employee. CNA2 could not verbalize how many residents should be assisted at one time. CNA2 verbalized hand hygiene should be performed after working with a resident and before working with a different resident. CNA2 confirmed CNA2 did not perform hand hygiene between the three residents CNA2 was assisting with their meal.</p> <p>On 04/30/2024 at 3:03 PM, the Dietary Manager verbalized any employee entering the kitchen (pantry) on the Units was required don a hairnet and perform hand hygiene at the sink in the kitchen area. The Dietary Manager verbalized employees were to wear gloves if touching food not prepackaged, like drinks. The Dietary Manager confirmed the employees were not required to wear gloves when serving plates and verbalized the employees should be serving the plates to the residents by holding the plate on the bottom of the plate.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Dietary Manager verbalized alcohol based hand sanitizer (ABHS) should be used by the employee to perform hand hygiene between serving each resident and every third plate served the employee was required to use soap and water to perform hand hygiene.</p> <p>On 04/30/2024 at 5:19 PM, the Assistant Director of Nursing (ADON) verbalized the CNAs provide meal service in the Units and should perform hand hygiene between residents.</p> <p>The facility policy titled Food Service: Sanitation and Safety, revised 07/2008, documented employees would thoroughly wash the employees hands with soap and water before starting work in the kitchen and during work as often as was necessary to keep them clean.</p> <p>The facility policy titled Food Service: Meal Service in Dining Room or Other Area,, last revised 08/2022, documented staff responsible for serving residents in the dining rooms shall wash hands. Staff shall use hand sanitizer between serving each resident unless the hands become soiled, then hands should be washed. No bare hands should touch any food items.</p>		