

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 08/22/2024
NAME OF PROVIDER OR SUPPLIER Highland Manor of Fallon Rehabilitation LLC		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 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** 34524</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure a resident was not verbally abused by a Certified Nursing Assistant (CNA) for 1 unsampled resident (Resident #17) and a resident was protected from resident-to-resident verbal abuse when a resident yelled racial slurs and profanity for 1 of 19 sampled residents (Resident #79).</p> <p>Findings include:</p> <p>An initial FRI dated 06/01/2024, documented a CNA became frustrated while trying to position a resident in a Hoyer lift and wrote on the resident's white board the resident was being over dramatic and was acting like a child.</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including monoplegia of lower limb following cerebral infarction affecting right dominant side, muscle wasting and atrophy, contractures of the left and right hands, and unspecified hearing loss, unspecified ear.</p> <p>On 08/21/2024 at 8:33 AM, a Licensed Practical Nurse (LPN) verbalized Resident #17 had hearing loss however the resident could read lips and used a white board to communicate.</p> <p>An Incident Note for Resident #17 dated 06/01/2024, documented the resident was being transferred via a Hoyer lift when a CNA became frustrated and wrote on the resident's communication board the resident was being over dramatic and acting like a child. The CNA stated the resident was heavy. The resident started to cry and was upset.</p> <p>On 08/21/2024 at 4:24 PM, the Abuse Coordinator verbalized the Administrator received a call regarding a CNA who got frustrated with Resident #17 while providing cares to the resident. The CNA wrote on the resident's communication board the resident was acting like a child and being over dramatic, and showed the resident the writing on the board. The CNA said out loud the resident was heavy and hard to reposition. The resident began to cry in response.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CNA admitted to writing those phrases on the white board and stated the CNA messed up and lost their temper. Two other CNAs provided witness statements detailing what happened between the resident and the CNA in question. The facility substantiated the allegation of verbal abuse and terminated the CNA in question.</p> <p>Cross reference with 609</p> <p>FRI00071364</p> <p>43310</p> <p>An initial FRI dated 05/17/2024, documented on 05/17/2024 Resident #79 made the Administrator aware Resident #61 yelled at Resident #79 using racial slurs and profanity.</p> <p>Resident #61</p> <p>Resident #61 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, violent behavior, and generalized anxiety disorder.</p> <p>A Discharge Plan Update note, dated 05/17/2024, documented Resident #61 continued to exhibit erratic and unpredictable aggressive physical/verbal behavior towards other residents and staff.</p> <p>A Nurse Progress note, entered by a Social Worker on 05/24/2024, documented Resident #61 continued to exhibit unpredictable and unprovoked physical and verbal behaviors towards others. The resident was discharged and readmitted to a psychiatric treatment facility.</p> <p>Resident #61's clinical record did not include documentation related to the incident occurring between Resident #61 and #79 on 05/17/2024.</p> <p>Resident #79</p> <p>Resident #79 was admitted to the facility on [DATE], and was last readmitted on [DATE], with a diagnosis of end stage renal disease.</p> <p>Resident #79's clinical record lacked documentation related to the incident occurring on 05/17/2024.</p> <p>On 08/22/2024 at 12:25 PM, Resident #79 confirmed Resident #61 had yelled at Resident #79 and used profanity and racial slurs. Resident #79 verbalized Resident #61 had gone away for a while but had since returned to the facility. Resident #79 verbalized avoiding Resident #61 and explained when Resident #61 was in activities, Resident #79 would not go into the Activities Room.</p> <p>On 08/22/2024 at 12:34 PM, the DON verbalized neither the DON or the Administrator worked at the facility during the time of the incident and the DON was not familiar with what had happened. The DON confirmed following a resident to resident altercation, the expectation was both residents would have follow-up visits completed by Nursing and Social Services within 72 hours of the incident.</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>The DON confirmed Resident #79's clinical record lacked documented evidence of the incident occurring on 05/17/2024, including progress notes, follow up notes and care plan.</p> <p>On 08/22/2024 at 1:04 PM, the Administrator was not able to confirm the incident had occurred due to not working at the facility during the time of the altercation and the lack of investigative report and/or other documentation related to the incident.</p> <p>The facility policy titled Abuse Policy, revised 06/11/2024, documented residents had the right to be free from all forms of abuse, including verbal abuse. Verbal abuse was defined as the use of oral, written or gestured language which included disparaging or derogatory terms to residents or within a residents hearing distance, regardless of the residents ability to comprehend. The facility provided emotional support and/or counseling to residents during and after the investigation as needed.</p> <p>FRI #NV00071212</p> <p>Cross Reference with F610, and F656</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524</p> <p>Based on interview, clinical record review, and document review the facility failed to submit a final Facility Reported Incident (FRI) report to the State Agency (SA) for 1 unsampled resident (Resident #17).</p> <p>Findings include:</p> <p>An initial FRI dated 06/01/2024, documented a CNA became frustrated while trying to position a resident in a Hoyer lift and wrote on the resident's white board the resident was being over dramatic and was acting like a child.</p> <p>A final FRI dated 06/07/2024 was submitted late to the SA.</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including monoplegia of lower limb following cerebral infarction affecting right dominant side, muscle wasting and atrophy, contractures of the left and right hands, and unspecified hearing loss, unspecified ear.</p> <p>On 08/21/2024 at 8:33 AM, an LPN verbalized Resident #17 had hearing loss however the resident could read lips used a white board to communicate.</p> <p>An Incident Note for Resident #17 dated 06/01/2024, documented the resident was being transferred via a Hoyer lift when a CNA became frustrated and wrote on the resident's communication board the resident was being over dramatic and acting like a child. The CNA stated the resident was heavy. The resident started to cry and was upset.</p> <p>On 08/21/2024 at 4:24 PM, the Abuse Coordinator verbalized the Administrator received a call a CNA got frustrated with Resident #17 while providing cares to the resident. The CNA wrote on the resident communication board the resident was acting like a child and being over dramatic, and showed the resident the writing on the board. The CNA said out loud the resident was heavy and hard to reposition. The resident began to cry in response.</p> <p>The CNA admitted to writing those phrases on the white board and stated they messed up and lost their temper. Two other CNAs provided witness statements detailing what happened between the resident and the CNA in question. The facility substantiated the allegation of verbal abuse and terminated the CNA in question. The Abuse Coordinator confirmed the final report was sent late to the SA.</p> <p>Cross reference with 600</p> <p>FRI00071364</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** 43310</p> <p>Based on interview, clinical record review, and document review the facility failed to investigate an allegation of resident-to-resident verbal abuse and submit a final Facility Reported Incident (FRI) report to the State Agency for 1 of 19 sampled residents (Resident #79). This deficient practice had the potential to allow allegations of abuse to occur and not be investigated by the facility and not reported to the State Agency with the potential for residents to be physically and/or psychosocially harmed.</p> <p>Findings include:</p> <p>Resident #61</p> <p>An initial FRI dated 05/17/2024, documented on 05/17/2024 Resident #79 made the Administrator aware Resident #61 yelled at Resident #79 using racial slurs and profanity.</p> <p>Resident #61 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, violent behavior, and generalized anxiety disorder.</p> <p>Resident #79</p> <p>Resident #79 was admitted to the facility on [DATE], and was last readmitted on [DATE], with a diagnosis of end stage renal disease.</p> <p>Resident #79's clinical record lacked documentation related to the incident occurring on 05/17/2024.</p> <p>On 08/22/2024 at 12:25 PM, Resident #79 confirmed Resident #61 had yelled at Resident #79 and used profanity and racial slurs. Resident #79 verbalized Resident #61 had gone away for a while but had since returned to the facility. Resident #79 verbalized avoiding Resident #61 and explained when Resident #61 was in activities, Resident #79 would not go into the Activities Room.</p> <p>On 08/22/2024 at 12:54 PM, the Administrator confirmed the facility lacked documented evidence a final FRI report was submitted to the State Agency and should have been submitted within five days of the incident.</p> <p>On 08/22/2024 at 1:00 PM, the Administrator verbalized when a resident to resident altercation occurred the top priority was to ensure both residents were safe, interviews with staff and other residents were conducted, and chart reviews were completed.</p> <p>On 08/22/2024 at 1:04 PM, the Administrator confirmed the facility lacked documented evidence an investigation into the allegations of resident to resident verbal abuse was conducted and confirmed an investigative report was not completed and/or kept by the facility.</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>On 08/22/2024 at 1:04 PM, the Administrator was not able to confirm the incident had occurred due to not working at the facility during at the time of the altercation and the lack of investigative report and/or other documentation related to the incident.</p> <p>The facility policy titled Abuse Policy, revised 06/11/2024, documented when an incident or suspected incident of resident abuse had occurred the Administrator and/or a designee, conducted and investigation of the alleged incident. The investigation included interviewing staff, residents, family members or others who had knowledge of the incident. A summary of the interviews was documented. The Administrator or the designee reviewed finding from abuse investigations with the facility's Quality Assurance committee to ensure a thorough investigation was conducted and residents were protected. The Administrator or designee reported the results of all investigations to the State Agency within five working days of the incident. If the alleged violation was substantiated, the appropriate corrective actions were taken.</p> <p>FRI #NV00071212</p> <p>Cross Reference with F600 and F656</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure psychotropic medications were care planned for 1 of 19 sampled residents (Resident #51), to ensure oxygen administration to include monitoring was care planned for 1 of 19 sampled residents (Resident #32), and a care plan related to resident to resident verbal abuse was initiated for 1 of 19 sampled residents (Resident # 79). This deficient practice had the potential for staff caring for the resident to not be aware of the severity of the resident's behavioral symptoms requiring management or the plan of care goals decided on by the interdisciplinary team with the potential for a resident to have a poor outcome as a result of not receiving individualized care.</p> <p>Findings include:</p> <p>Resident #51</p> <p>Resident #51 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including atherosclerosis of aorta, other lack of coordination, and Alzheimer's disease, unspecified.</p> <p>The medication orders and the August 2024 Medication Administration Record (MAR) for Resident #51 documented the following:</p> <ul style="list-style-type: none"> - Clonazepam oral tablet 0.5 milligrams (mg), give 0.5 mg orally at bedtime related to generalized anxiety disorder. The order date was 06/17/2024. - Effexor extended-release oral capsule 37.5 mg, give 75 mg by mouth at bedtime related to depression, unspecified. The order date was 07/26/2024. <p>The Care Plan for Resident #51 lacked documentation of the Clonazepam and Effexor.</p> <p>On 08/21/2024 at 1:54 PM, the Licensed Practical Nurse (LPN) for Resident #51 verbalized a care plan would be developed for a psychotropic medication when the medication was ordered for the resident.</p> <p>On 08/21/2024 at 2:45 PM, the Director of Nursing (DON) confirmed a care plan should have been developed for the psychotropic medications prescribed for Resident #51.</p> <p>The facility policy titled Psychoactive Medication Use, Intervention and Monitoring, revised 12/2016, documented the interdisciplinary team members of the psychotropic committee would be responsible for developing a plan of care. The resident or representative would be involved in the development and implementation of the care plan.</p> <p>30748</p> <p>Resident #32</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia, chronic cough, and paroxysmal atrial fibrillation.</p> <p>On 08/19/2024 at 11:01 AM, Resident #32 was seated in a wheelchair with a portable oxygen concentrator hanging on the back of the wheelchair. Next to the resident's bed was an oxygen concentrator. Resident #32 explained being on oxygen continuously at five liters per minute (LPM) because of the resident's heart conditions.</p> <p>A physician's order dated 08/19/2024, documented Oxygen at five LPM via nasal cannula continuous for shortness of breath.</p> <p>Resident #32's Comprehensive Care Plan lacked documented evidence of a care plan for the administration and monitoring of Oxygen.</p> <p>On 08/20/2024 at 10:57 AM, an LPN explained Resident #32 was on five LPM of Oxygen continuously for chronic obstructive pulmonary disease, exacerbation and a history of hypoxia. The resident had episodes of desaturations.</p> <p>The LPN verbalized a care plan was required for the administration of Oxygen to residents in order to explain the residents care needs to staff. The LPN confirmed Resident #32 did not have a care plan for the administration and monitoring of Oxygen.</p> <p>On 08/20/2024 at 11:16 AM, the DON explained the purpose of a care plan was to document the needs of residents to be addressed and how the staff were going to meet a resident's care needs. The DON confirmed Resident #32 lacked a care plan for the administration and monitoring of Oxygen and verbalized the DON expected Oxygen to be documented on a care plan.</p> <p>The facility policy titled Care Plans, Comprehensive and Revisions, last revised December 2016, documented comprehensive care planning included an assessment of residents strengths and needs and would include goals for care required for the resident. The purpose of the person-centered care plan was to describe services furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being.</p> <p>43310</p> <p>A FRI report dated 05/17/2024, documented on 05/17/2024, Resident #79 made the Administrator aware a resident yelled at Resident #79 using racial slurs and profanity.</p> <p>Resident #79</p> <p>Resident #79 was admitted to the facility on [DATE], and was last readmitted on [DATE], with a diagnosis of end stage renal disease.</p> <p>Resident #79's clinical record lacked documentation, including a care plan, related to a resident to resident verbal abuse occurring on 05/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/22/2024 at 12:34 PM, the DON confirmed Resident #79's clinical record lacked documented evidence of the incident occurring on 05/17/2024, including progress notes, follow up notes and a care plan.</p> <p>FRI #NV00071212</p> <p>Cross reference with F600 and F610</p>		