STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Fallon Rehabilitation LLC	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure a resident's representative gave consent to the use of a psychotropic medication prior to the medication being administered for 2 of 19 sampled residents (Resident #51 and #32). This deficient practice had the potential for a resident to receive a medication without being fully informed of all potential side effects and adverse reactions or a medication the resident did not wish to receive. Findings include: Resident #51 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. The medication orders for Resident #51 documented the following: - Depakote oral tablet delayed release 125 milligrams (mg), give one tablet by mouth two times a day related to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. The order date was 07/10/2024. The July and August 2024 Medication Administration Records for Resident #51 documented the Depakote had been administered as ordered apart from nine doses refused by the resident since the initiation of the medication on 07/10/2024. A Consent for Psychotropic Medication Use, dated 08/07/2024, documented the Depakote 125 mg, had been prescribed as a mood stabilizer for the resident's diagnosis of dementia with behaviors. The verbal consent for the resident to receive the medication was documented as obtained from the resident's power of attorney on 08/07/2024. On 08/21/2024 at 1:54 PM, the Licensed Practical Nurse (LPN) for Resident #51 verbalized consent would be obtained from the resident or a representative prior to the first administration of a psychotropic medication. On 08/21/2024 at 2:45 PM, the Director of Nursing (DON) confirmed a consent should have been completed for the Depakote prior to administering the medication to Resident #51. (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

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	30748 Resident #32 Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including depression, unspecified, insomnia, unspecified, and cognitive communication deficit. A physician's order dated 08/08/2024, documented Trazodone Hydrochloride (HCl), oral tablet, 50 mg. Give one and a half tablets by mouth at bedtime related to insomnia, unspecified. Resident #32's clinical record lacked documented evidence of a completed informed consent for psychotropic drugs prior to the administration of Trazodone HCl 50 mg. On 08/21/2024 at 12:31 PM, the DON explained Trazodone was prescribed to the resident for insomnia and would require a consent to treat the resident prior to administering the Trazodone. The DON confirmed no consent was completed to treat the resident prior to administering Trazodone. The facility policy titled Psychoactive Medication Use, Intervention and Monitoring, revised 12/2016, documented the resident and family/representatives would be informed of the potential risks and benefits of proposed interventions. The resident and/or resident surrogate would have the right to refuse treatment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on clinical record review, interview, and document review the facility failed to ensure 1 of 19 sampled residents' (Resident #44) Minimum Data Set 3.0 (MDS) assessment was accurately completed. Findings include: Resident #44 Resident #44 was admitted to the facility on [DATE], with a diagnosis of essential (primary) hypertension. On 08/19/24 at 11:23 AM, resident verbalized she did not receive dialysis and had not received dialysis in the past. Resident #44's clinical record lacked documented evidence the resident was on dialysis, including progress notes, a care plan, and a physician's order to receive dialysis. An Admissions MDS assessment dated [DATE], Section O, item J documented 'no' for dialysis. A Quarterly MDS assessment dated [DATE], 11/05/2023, 02/02/2024, and 05/03/2024, Section O, item J documented no for dialysis. An annual MDS assessment dated [DATE], Section O, item J documented no for dialysis. A Quarterly MDS assessment dated [DATE], Section O, item J documented yes for dialysis. The next quarterly MDS assessment dated [DATE], remained in progress. On 08/20/2024 at 1:08 PM, the MDS Coordinator/Registered Nurse (RN) confirmed Resident #44's MDS assessment dated [DATE], documented the resident was on dialysis and should not have been marked for dialysis due to the resident did not at any time receive dialysis treatments. MDS accuracy was important not only for reimbursement concerns, but also for accuracy of diagnoses and resident care plans.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review and document review, the facility failed to initiate a submission for a determination of a Preadmission Screening and Resident Review (PASARR) level II for 1 of 19 sampled residents with a mental illness diagnosis of schizoaffective disorder (Resident #37). Findings include: Resident #37 Resident #37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including schizoaffective disorder, hallucinations, unspecified, anxiety disorder due to known physiological condition, and dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. Resident #37's PASARR Level I documented completion on 07/03/2018. The PASARR Level 1 documented IC - no Mental Illness, Mental Retardation, or Related Conditions. PASARR appropriate for Nursing Facility (NF) placement. A Level of Care maybe required for placement. Resident #37's Level of Care Determination (LOC) dated 05/21/2021, documented meets NF LOC. No further LOC Screening was required unless the screening was limited or if a significant change occurs with the resident's status, which suggested a change in treatment needs for those conditions. A Physician Progress Note dated 11/09/2023, documented Resident #37 was admitted to inpatient behavioral health for psychosis, aggressive behavior, and resistance to cares. Resident #37's clinical record lacked documented evidence a PASARR Level II was submitted for determination. Resident #37's Care Plan, initiated 07/14/2024, documented the resident had verbal and sometimes physical behaviors towards others related to schizoaffective disorder, bipolar type, and dementia. On 08/21/2024 at 8:51 AM, a Licensed Practical Nurse (LPN) verbalized Resident #37 had hallucinations and would speak to people that weren't there, and was often combative with cares. On 08/21/2024 at 3:17 PM, the Administrator verbalized Resident #37 was transferred to an inpatient behavioral health facility due to the resident's behaviors. The Administrator confirmed the resident had a diagnosis of schizophrenia and a PASARR Level II was not submitted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 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. Findings include: Resident #51 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. The medication orders and the August 2024 Medication Administration Record (MAR) for Resident #51 documented the following: - 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. The Care Plan for Resident #51 lacked documentation of the Clonazepam and Effexor. 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. 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. 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. 30748 Resident #32 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. A physician's order dated 08/19/2024, documented Oxygen at five LPM via nasal cannula continuous for shortness of breath. Resident #32's Comprehensive Care Plan lacked documented evidence of a care plan for the administration and monitoring of Oxygen. 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. 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. 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. 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. 43310 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. Resident #79 Resident #79 was admitted to the facility on [DATE], and was last readmitted on [DATE], with a diagnosis of end stage renal disease. Resident #79's clinical record lacked documentation, including a care plan, related to a resident to resident verbal abuse occurring on 05/17/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. FRI #NV00071212 Cross reference with F600 and F610

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview, clinical record review, and document review, the facility failed to honor an intervention involving a recliner, aimed to aid sleep, for a resident exhibiting resistive care behaviors and who did not sleep in a bed, for 1 of 19 sampled residents (Resident #74). Findings include: Resident #74 Resident #74 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paranoid schizophrenia, major depressive disorder, recurrent, moderate, and unspecified dementia, severe, with anxiety. On 08/19/2024 at 12:17 PM, Resident #74's mattress was on the floor in the room with a fall mat placed next to the mattress. No other personal items were located in the resident's room. Resident #74's Comprehensive Care Plan for behaviors-resisting cares and psychotropic medication use dated 05/13/2024, and revised on 08/19/2024, documented the resident had behaviors of resisting cares, not sleeping, throwing cups of liquid, striking out at others, screaming constantly, cursing and agitation due to diagnoses of schizophrenia and dementia with behavioral disturbance. Interventions on the care plan included the resident preferring to sleep on the floor mat and appeared to sleep better while on it. Per the resident's daughter the resident used to sleep on a recliner at home. The floor mat would remain in place and a recliner placed in the resident's room. A physician's order dated 07/01/2024, documented the head of bed elevations was needed due to shortness of breath every shift for shortness of breath. On 08/21/2024 at 12:09 PM, the resident's mattress was still on the floor of the room, with the fall mat located next to the mattress. No other personal items were in the resident's room. On 08/21/2024 at 12:38 PM, the Director of Nursing (DON) explained Resident #74 was difficult to deal with at times because of the resident's behaviors. The resident would not lay down on the resident's mattress most times and would fall asleep in the wheelchair. If staff attempted to get the resident in bed, the resident would not stay on the mattress for long and get back up. The DON confirmed there was a physician's order to elevate the resident's head of the bed for shortness of breath and verbalized placing the resident on the mattress on the floor could be dangerous for the resident. The head of the bed would not be able to elevate causing the resident to not be able to breathe. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was unaware of conversations occurring with the resident's daughter about placing a recliner in the resident's room and verbalized no attempt was made to place a recliner in the resident's room to try sleeping on. The DON confirmed the resident's comprehensive care plan intervention of placing a recliner in the resident's room for the purpose of sleeping comfort for the resident were not honored nor revised to exclude the recliner, if needed. On 08/21/2024 at 2:04 PM, Resident #74's daughter explained the resident loses sleep and would not sleep in a bed any longer. The resident would avoid sleeping in a bed because the resident was afraid of falling. As a result, the resident would sleep on the couch at times and in a recliner. The daughter confirmed not seeing a recliner in the resident's room nor any knowledge a recliner had been attempted to help the resident sleep. The facility policy titled Care Plans, Comprehensive and Revisions, last revised December 2016, documented the facility would develop and implement a Comprehensive Person-Centered Care Plan appropriate for each resident and would include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the resident's comprehensive assessment.

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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** 34524 Based on interview, clinical record review, and document review, the facility failed to ensure a resident dependent upon staff for Activities of Daily Living (ADLs) received showers for 1 of 19 sampled residents (Resident #46). Findings include: Resident #46 Resident #46 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy and muscle weakness (generalized). On 08/19/2024 at 1:28 PM, Resident #46's spouse verbalized the resident had not received two showers per week. The resident's spouse explained the resident was scheduled to receive showers on Wednesdays and Saturdays and had not received showers the last two Saturdays. On 08/19/2024 at 1:30 PM, Resident #46 verbalized the resident had not received showers the previous two Saturday shower days. Resident #46's clinical record lacked documented evidence the resident received or refused showers. On 08/20/2024 at 10:10 AM, a Certified Nursing Assistant (CNA) verbalized residents received two showers per week and shower days were scheduled based on room assignments. The CNA explained Resident #46's showers were scheduled on Wednesdays and Saturdays. Showers given and showers refused would be documented in the residents electronic medical record. On 08/20/2024 at 10:13 AM, a Licensed Practical Nurse (LPN) verbalized Resident #46's showers were scheduled on the evening shift on Wednesdays and Saturdays. The LPN explained Resident #46 did not always get their showers on the evening shift due to time constraints. The LPN was working on changing the resident's shower schedule from the evening shift to the day shift. On 08/22/2024 at 11:55 AM, the Regional Clinical Resource verbalized residents were to receive showers twice a week. The Regional Clinical Resource confirmed Resident #46's clinical record lacked documentation showers were given or refused. The facility policy titled Facility Shower Policy, undated, documented the facility was committed to providing personalized care regarding shower frequency and timing.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 30748 Based on interview, personnel record review, and document review, the facility failed to employ a trained Activities Director or a qualified professional to provide oversight to the activities department. Findings include: On 08/20/2024 at 8:32 AM, the State Agency was attempting to set up a Resident Council Meeting with the Activities Director. An employee in the activities room verbalized filling in for the Activities Director because the facility did not currently have an Activities Director. The employee explained filling in for the Activities Director, as an Activities Assistant, for the past three to four months. On 08/20/2024 at 9:12 AM, the Business Office Manager verbalized the Activities Assistant was the Activities Director for a total of six months, however resigned from the position a few weeks ago and the employee was creating activities calendars and setting up activities to do with the residents daily. The Business Office Manager searched for the employee's Activities Director qualifications and training requirements and could not produce the documents requested related to the Activities Assistant. The Business Office Manager confirmed the facility lacked an Activities Director for the past six months. On 08/20/2024 at 1:26 PM, the Administrator verbalized the facility had an Activities Director, and identified the Activities Assistant. The Administrator explained the facility also had an activities consultant who would help obtain certifications for a qualified Activities Director and the Activities Assistant was creating activities calendars and doing activities with the residents daily. The Administrator explained the Activities Assistant completed the required courses, deeming the Activities Assistant qualified to be the Activities Director for the facility and would provide the completed course certificates for the Activities Assistant. The documentation requested could not be provided by the facility prior to completing the federal recertification survey. On 08/20/2024 at 1:53 PM, the Activities Assistant confirmed not being the Activities Director and did not complete any classes related to becoming the Activities Director, as required. The Activities Assistant explained the Activities Assistant was supposed to start the required classes, however, did not enroll in any of the classes prior to resigning from the Activities Director role in May 2024. The Activities Assistant explained being responsible for creating activities calendars, completing resident assessments, and care plans and was only working part time at the facility currently. On 08/20/2024 at 2:11 PM, the Consultant explained the Activities Assistant was acting in the role of the Activities Director and the Consultant was responsible for training and certifying employees for the Activities Director position. The Consultant verbalized the Activities Assistant did not do the required training to be in the Activities Director position, however was completing activities calendars for the residents. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consultant explained being a consultant for the facility and was required to complete 20 hours of consulting every month as a part of the contract signed with the facility but was only completing 10 hours or less a month. The Consultant described also not being the Activities Director for the facility and was only conducting reviews for activities for the facility. The Consultant confirmed the Activities Assistant was not qualified to be the Activities Director and the facility had been without an Activities Director for quite some time. An Agreement for Activity Consultant dated 04/29/2024, documented the Consultant was to work a minimum of 20 hours per month providing professional guidance and consultation to the Activities Director to enhance activity programming. A Receipt of Services, with a submission date of 08/13/2024, documented the Consultant worked a total of three and a half hours for the month of July 2024. The personnel roster provided to the State Agency documented the Activities Assistant was identified as the Activities Director. A personnel tracker for the Activities Assistant, provided by the Business Office Manager documented the following: -The Activities Assistant started at the facility as a Certified Nursing Assistant (CNA) until 10/21/2023. -The CNA was then promoted to the Director of Memory Care on 10/22/2023, until 02/24/2024. -The Director of Memory Care was promoted to Activities Director on 02/25/2024, with no termination date. A resignation letter dated 05/21/2024, documented the Activities Assistant was resigning from the position of Activities Director effective June 5, 2024. The Activities Director had a start date of 02/25/2024. The personnel record lacked documented evidence of certification or training as an activities professional by a recognized accrediting organization. The personnel record included a facility position description titled, Activities Director, completed and signed by the Activities Assistant on 07/01/2024. The position description documented the Activities Director was responsible for the planning, developing, organizing, implementing, evaluating, and directing the activity programs in accordance with current existing federal and state regulations and facility policies and procedures. The position description documented the Activities Director must have or obtain an active license, at a minimum, as a Therapeutic Recreational Therapist. The position description lacked language to include the role and responsibilities of a certified activities professional to direct the facility's activities program during the period a new Activities Director was obtaining certification.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review, and document review, the facility failed to ensure a Physical Therapy (PT) evaluation was completed for a resident identified as a fall risk for 1 of 19 sampled residents (Resident #46). Resident #46 Resident #46 was admitted to the facility on [DATE], with diagnoses including hereditary motor and sensory neuropathy, muscle weakness (generalized), and history of falling. On 08/19/2024 at 10:28 AM, Resident #46 verbalized the resident had a rare hereditary condition that caused weakness of the legs and required the resident to wear braces on both lower legs. The resident had a fall prior to admitting to the facility and had been waiting to receive physical therapy. On 08/21/2024 at 8:45 AM, a Licensed Practical Nurse (LPN) verbalized Resident #46 had issues with their legs and did not have control of them. The LPN explained the resident wore braces on their legs for contractures and to prevent drop foot. Resident #46's Comprehensive Care Plan initiated 06/01/2024, documented Resident #46 was at risk for falls related to deconditioning, gait/balance problems, unaware of safety needs. Interventions included refer to therapy for evaluation and treatment as indicated to address fall risk. Resident #46's clinical record lacked evidence of a Physical Therapy evaluation. On 08/21/2024 at 12:05 PM, the Director of Rehabilitation verbalized Resident #46 had not received a PT evaluation and was not receiving PT services. Resident #46's MORSE Fall Evaluation dated 06/01/2024, documented the resident was at moderate risk of falling. On 08/22/2024 at 11:16 AM, the Director of Nursing (DON) verbalized Resident #46 was at risk for falling and was care planned for risk of falling. The DON explained the residents care plan for falls included the intervention of a referral to PT for evaluation. The DON confirmed the resident did not receive a PT evaluation and should have received the PT evaluation within 10 days of admission. The facility policy titled Falls - Clinical Protocol, adopted 12/19/2026, documented as part of the initial assessment, nursing staff would identify individuals with a history of falls and risk factors for subsequent falling. The staff would document risk factors for falling in the resident's record and address the resident's fall risk.

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	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview, clinical record review and document review, the facility failed to ensure Oxygen was administered as ordered for 1 of 19 sampled residents (Resident #32). Findings include: Resident #32 Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia, chronic cough, and paroxysmal atrial fibrillation. 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 and the concentrator was turned on, while the resident was not getting Oxygen administered from the concentrator. On 08/19/2024 at 11:11 AM, a Certified Nursing Assistant (CNA) confirmed the oxygen concentrator was actively administering Oxygen while the resident was not connected to the device. A physician's order dated 08/19/2024, documented Oxygen at five liters per minute (LPM) via nasal cannula continuous for shortness of breath. On 08/20/2024 at 10:51 AM, Resident #32 was sleeping in bed. The oxygen concentrator was administering Oxygen at five LPM. The nasal cannula was not affixed to the resident's face and was located on the bed in front of the resident's chest. On 08/20/2024 at 10:54 AM, a CNA entered the resident's room and confirmed the resident's nasal cannula which should administer Oxygen continuously, was not in place The CNA verbalized the resident was to be on Oxygen on a continuous basis. On 08/20/2024 at 10:57 AM, a Licensed Practical Nurse (LPN) explained the resident was on Oxygen for chronic obstructive pulmonary disease, exacerbation and a history of hypoxia. The resident was to be on Oxygen on a continuous basis to prevent exacerbation. On 08/20/2024 at 11:16 AM, the Director of Nursing (DON) explained the resident was to be on Oxygen on a continuous basis and would expect the resident to be on Oxygen via nasal cannula at all times to avoid a negative respiratory outcome and Oxygen levels decreasing. The facility policy titled Oxygen Administration, last revised October 2010, documented physician's orders related to the administration of oxygen were to be followed at all times to provide safe oxygen administration to residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Following Physician Orders Policy, undated, documented staff would comply with physician order instructions as prescribed and implement exactly as written. This would ensure all staff at the facility would implement physician orders accurately and promptly to provide safe and effective patient care in compliance with medication directives and facility standards.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure 1) pain medications were administered timely when Lidoderm External Patches (Lidocaine patches) were administered late for a resident diagnosed with pain for 1 of 19 sampled residents (Resident #80), and 2) Lidocaine patches were available and administered for 2 of 19 sampled residents (Resident #80 and #79). Findings include: Resident #80 Resident #80 was admitted to the facility on [DATE], with diagnoses including other intervertebral disc degeneration, lumbar region, and pain, unspecified. Late Administration A physician's order dated 07/25/2024, documented Lidocaine patches. Apply to lower back topically one time a day for pain. Remove after twelve hours. On 08/21/2024 at 7:40 AM, a Licensed Practical Nurse (LPN1) explained the order for Resident #80 was scheduled to be administered at 7:00 AM to 9:00 AM. LPN1 explained nurses applied the Lidocaine patches at 8:00 AM and removed at 8:00 PM. The LPN verbalized nurses had one hour before and one hour after the scheduled times to administer medications and the latest the LPN could administer the Lidocaine patches would be 10 AM. Resident #80's care plan with a focus initiated 07/18/2024, documented pain. The resident had potential for altered comfort related to chronic back pain related to disc degeneration. An intervention initiated 07/30/2024, documented to administer pain medication as ordered including Lidocaine patches. Resident #80's August 2024 Medication Administration Record (MAR) documented Lidocaine patches. Apply to the lower back topically one time a day for pain. Remove after twelve hours. The Lidocaine patch was scheduled during the morning medication pass at 7:00 AM. The Lidocaine patches were administered late on the following dates and times: -on 08/05/2024 at 10:34 AM -on 08/11/2024 at 12:01 PM -on 08/15/2024 at 10:35 AM. (continued on next page)

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	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 7:40 AM, LPN1 verbalized the LPN knew when to administer medications because the order showed throughout the shift or scheduled administration times. LPN1 confirmed Resident #80's MAR documented Lidocaine patches were administered late on 08/05/2024, 08/11/2024, and 08/15/2024. The LPN verbalized when a medication was administered late, there should be a progress note describing the situation. The LPN verbalized the late administration of Lidocaine patches could result in increased pain. On 08/21/2024 at 11:28 AM, the Director of Nursing (DON) explained if Lidocaine patches were scheduled for 7:00 AM to 9:00 AM, the administering nurse had one hour before 7:00 AM and one hour after 9:00 AM to administer the medication. The DON confirmed the administrations of Lidocaine patches on 08/05/2024 at 10:34 AM, 08/11/2024 at 12:01 PM, and 08/15/2024 at 10:35 AM would be considered late administrations. On 08/21/2024 at 12:09 PM, the Medical Director (MD) explained medications should be administered within the right time frame of the order's schedule. The facility policy titled Administering Medications, revised 04/2019, documented medications were to be administered within one hour of their prescribed time unless otherwise specified. Lidocaine patches Not Available A physician's order dated 07/25/2024, documented Lidocaine patches. Apply to lower back topically one time a day for pain. Remove after twelve hours. On 08/19/2024 at 11:10 AM, Resident #80 verbalized there were a few days when the facility did not have Lidocaine Patches to administer to the resident for pain. Resident #80's July MAR documented nines for Lidocaine patch administration on the following dates at morning medication pass on: 07/26/2024, 07/27/2024, 07/28/2024, and 07/29/2024. Resident #80's Orders-Administration Progress Notes documented the following: -Effective date 07/26/2024 at 8:16 AM, Lidocaine patch. Apply to lower back topically one time a day for pain. Remove after twelve hours. Out of stock, on order. -Effective date 07/27/2024 at 8:30 AM, Lidocaine patch. Apply to lower back topically one time a day for pain. Remove after twelve hours. Patch on order. -Effective date 07/28/2024 at 8:55 AM, Lidocaine patch. Apply to lower back topically one time a day for pain. Remove after twelve hours. Medication not available, MD notified. -Effective date 07/29/2024 at 8:42 AM, Lidocaine patch. Apply to lower back topically one time a day for pain. Remove after twelve hours. Medication on order. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 7:40 AM, LPN1 verbalized the LPN ensured medications were on site and available by pulling a medication sticker to fax to the pharmacy when eight administrations remained. If no administrations remained, the LPN would call the pharmacy for overnight shipping, document in progress notes and document on the resident's MAR. If a medication was not administered to a resident as a result of no remaining administrations, the LPN would consider it a medication error, and the LPN would notify the doctor and document. The LPN explained the risks of missed Lidocaine patches included increased pain for the resident. On 08/21/2024 at 10:59 AM, the DON explained the facility contracted pharmacy was out of state, so the facility did not receive same-day medication delivery and the facility was often worried about running out of medications. The DON expected nurses to reorder a medication with a pharmacy fax call report when there was a seven-day supply of medication remaining. If no administrations remained, the DON expected nurses to document and inform the doctor. The DON explained nines on the MAR indicated the resident did not receive a medication. The DON confirmed the nines on Resident #80's July 2024 MAR for Lidocaine patch administration on, 07/26/2024, 07/27/2024, 07/28/2024, 07/29/2024. The DON verbalized the Lidocaine patches were not on site because the pharmacy did not deliver them, and explained it was ultimately the responsibility of the facility to ensure medications were on site. The DON verbalized the pharmacy fax call reports would be in the Pharmacy Fax Call Report binder. On 08/21/2024 at 12:30 PM, the DON verbalized the July 2024 and August 2024 pharmacy fax call reports for Resident #80 could not be found. The Use of Outside Pharmacy Agreement documented the facility assumed responsibility for obtaining pharmaceutical and consultation services by a licensed pharmacist that met professional standards and principals including timeliness of services. A facility policy titled, Medication Ordering Policy, undated, documented the facility nurse was responsible for contacting the pharmacy to place new medication orders or request refills as needed. For new orders, the nurse would confirm the order details and ensure the prescription was processed promptly. 34524 Resident #79 Resident #79 was admitted to the facility on [DATE], with diagnoses including effusion, right knee and pain, unspecified. On 08/19/2024 at 3:00 PM, Resident #79 verbalized the resident has 10 out of 10 knee pain and takes pain medications and Lidocaine patches to manage the pain. The resident explained the facility has run out of Lidocaine patches and the resident went without for a couple of weeks. A physician order dated 06/10/2024, documented Lidocaine external patch 4 percent (%), apply to right knee topically one time a day related to pain, unspecified. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 2:42 PM, LPN2 verbalized Resident #79 received pain medication, Voltaren gel, and Lidocaine patches for knee pain. The LPN explained the facility had been out of Lidocaine patches recently and the resident was not able to receive them during the time the facility did not have them in the building. On 08/22/2024 at 9:24 AM, LPN3 verbalized the facility had been out of lidocaine patches. LPN3 explained the patches were over the counter and were not provided by the pharmacy. An Orders-Administration Note dated 07/19/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Unavailable, on order with supply. An Orders-Administration Note dated 07/20/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Unavailable, pending pharmacy, MD notified. An Orders-Administration Note dated 07/22/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. No patches available, on order. An Orders-Administration Note dated 07/23/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. No patches available. An Orders-Administration Note dated 07/26/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. On order. An Orders-Administration Note dated 07/27/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Out of stock, on order. An Orders-Administration Note dated 07/28/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Medication on order, not available in e-kit. MD notified. On 08/22/2024 at 9:29 AM, the DON verbalized the facility was out of lidocaine patches for a period of time due to a lost shipment. The DON confirmed the resident did not receive the lidocaine patches as ordered. The DON explained the Lidocaine patches could be purchased over the counter and the facility should have gotten some for the resident and did not. The facility policy titled Administering Medications, revised 04/2019, documented medications were to be administered within one hour of their prescribed time unless otherwise specified.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure a resident was reassessed for risk of entrapment after assessed to have a severe cognitive decline and prior to placing the resident in a bed with side rails for 1 of 19 sampled residents (Resident #52) and ensure residents were assessed for risk of entrapment prior to placing side rails on the residents bed for 2 of 19 sampled residents (Resident #134 and). Findings include: Resident #52 Resident #52 was admitted to the facility on [DATE], and readmitted on [DATE], and 07/22/2024, with diagnoses including encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee, acquired absence of left leg below knee, cognitive communication deficit, disorientation, unspecified, and dementia in other diseases classified elsewhere, mild, with other behavioral disturbance. On 08/19/2024 at 10:44 AM, Resident #52 was resting in bed, there were side rails on both sides of the bed, both side rails were raised. On 08/21/2024 at 10:07 AM, Resident #52 was resting in bed, there were side rails on both sides of the bed, both side rails were raised. A physician's order dated 04/24/2024, documented may use upper half side rails when in bed as an enabler to aid with bed mobility, turning, and repositioning. A Minimum Data Set 3.0 (MDS) assessment dated [DATE], Section C, documented Resident #52's Brief Interview for Mental Status (BIMS) score was 12, indicating the resident was cognitively intact. An MDS assessment dated [DATE], Section C, documented Resident #52 had a BIMS score of zero, indicating the resident had severe cognitive impairment. A facility form titled Assistive Device/Potential Restraint Quarterly Evaluation, dated 06/01/2024, documented the resident was approved for the use of assistive devices/potential restraints. Resident #52's clinical record lacked documented evidence an Assistive Device/Potential Restraint Evaluation form was completed when the resident was readmitted to the facility on [DATE], and 07/22/2024, prior to being placed into a bed with side rails. Resident #52's clinical record lacked documented evidence an Assistive Device/Potential Restraint Evaluation form was completed when the resident was assessed to have had a cognitive decline as indicated on the resident's MDS assessment dated [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The form asked if the resident had the potential to become entrapped or harmed by the use of the device, but did not include a quantitative assessment of data such as the size of the mattress, the fit of the mattress to the bed frame, gaps between the bed frame, mattress, and side rail, or gaps under the side rails and/or within the structure of the side rails. The resident information requested on the form did not include questions related to resident risk for entrapment, such as cognition, physical ability to raise and lower the side rails and/or the ability of the resident to remove themselves from entrapment if needed. On 08/20/2024 at 3:52 PM, the DON confirmed residents who were not cognitively intact should not have side rails and confirmed on a day to day basis Resident #52 was not cognitively intact and explained the resident had a decline in cognition over the past two to two and a half weeks. On 08/20/2024 at 3:56 PM, the DON confirmed when Resident #52 was noted to have had a cognitive decline, the residents risk for entrapment should have been reassessed and was not. On 08/21/2024 at 10:07 AM, Resident #52 verbalized the resident used the side rails to hold on to and added what the hell else would I do with them? Hang myself? When asked what the resident would do if the resident became trapped between the side rail and the bed, the resident replied, well, let's hope I slip through. On 08/21/2024 at 2:00 PM, the DON explained the DON assessed Resident #52 for entrapment risk on 08/20/2024, and asked the resident what the resident would do if an arm became trapped in the side rails and verbalized the resident replied, I would pull my arm out and when asked what the resident would do if the resident could not remove the resident's arm from the side rails, the resident responded they would call out for help. The DON confirmed the resident was not requested to demonstrate ability. The DON verbalized when using the Assistive Device/Potential Restraint Evaluation form one had to use their nursing judgement. On 08/21/2024 at 2:05 PM, the DON verbalized entrapment assessments were usually done by the admission nurse, or the MDS nurse by completing an Assistive Device/Potential Restraint Evaluation form was completed. The Admit Nurse completed entrapment assessments upon admit and the MDS Coordinator completed the assessments quarterly. On 08/21/2024 at 2:09 PM, the DON confirmed bed frames and mattress were not measured, and the resident was not assessed for physical stature related to the potential for entrapment prior to the instillation and use of side rails. The DON expressed everyone worked with the resident and if anyone had a concern, the DON was sure they would raise an objection. On 08/21/2024 at 3:11 PM, a Registered Nurse (RN) explained the Assistive Device/Potential Restraint Evaluation form was not in the facility's electronic health record (EHR) system used for resident assessments and documentation, including at admit. The form was only completed if the resident requested side rails or was a fall risk. Side rails were indicated for residents who needed the rails to pull themselves up and to prevent falls for residents with frequent falls. On 08/21/2024 at 3:17 PM, an RN verbalized Resident #52 used the side rails to help with turns and repositioning. The RN expressed if Resident #52 became entrapped in the side rails, the resident would not be strong enough to get out. (continued on next page)

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F 0700

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The facility policy titled Proper Use of Side Rails, dated 12/2016, documented an assessment of the resident was made and included the device to be used, cognitive status, physical status, a review of whether the resident had the potential to become entrapped or harmed, and risk factors associated with use of the device. The resident was reevaluated quarterly and as needed with significant changes for safety relative to side rail use. The facility assessed the space between the mattress and side rails to reduce the risk of entrapment. The amount of safe space varied depending on the type of bed and mattress being used.

30748

Resident #134

Resident #134 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unqualified visual loss, both eyes, unspecified osteoarthritis, unspecified site and difficulty in walking, not elsewhere classified.

On 08/19/2024 at 11:13 AM, Resident #134's bed had half side rails up on both sides of the bed. Resident #134 verbalized the side rails were placed on the bed per the resident's request so the resident could get out of bed.

Resident #134's clinical record lacked documented evidence a physician's order was obtained for half side rails.

Resident #134's clinical record lacked a safety assessment for the use of side rails and an informed consent to include the risks and benefits of side rails was obtained prior to the installation of the side rails.

On 08/21/2024 at 12:54 AM, the DON explained Resident #134 needed extensive assistance with the resident's Activities of Daily Living (ADL) and the side rails were installed on the resident's bed as a result. The DON verbalized a safety assessment was to be completed to determine if side rails were safe to use with the resident and an informed consent needed to be obtained to include the risks and benefits for the use of side rails prior to the installation of side rails on a residents bed. The DON confirmed the resident did not have a safety assessment completed nor an informed consent to include the risks and benefits.

The DON explained without the safety assessment completed, the staff would be unaware of any safety concerns with the resident using side rails and could be a safety hazard and/or a restraint for Resident #134. The resident could be at risk for entrapment and be strangled as a result.

On 08/21/2024 at 3:11 PM, an RN explained the Assistive Device/Potential Restraint Evaluation form was not in the facility's electronic health record (EHR) system used for resident assessments and documentation, including at admit. The form was only completed if the resident requested side rails or was a fall risk. Side rails were indicated for residents who needed the rails to pull themselves up and to prevent falls for residents with frequent falls.

34524

Resident #37

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including schizoaffective disorder, hallucinations, unspecified, anxiety disorder due to known physiological condition, and dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. On 08/19/2024 at 2:27 PM, side rails were in the down position on both sides of the resident's bed. On 08/21/2024 at 8:51 AM, a Licensed Practical Nurse (LPN) verbalized Resident #37 had side rails on their bed and used the side rails to pull self-up and hold position while staff provided cares. A physician order dated 05/29/2024, documented bilateral upper half side rails to use as an enabler to aid in bed mobility. Resident #37's care plan initiated 06/07/2024, documented impaired bed mobility, may use bilateral upper half side rails when in bed. Resident #37's clinical record lacked a safety assessment for the use of side rails and an informed consent to include the risks and benefits of side rails was obtained prior to the installation of the side rails. On 08/21/2024 at 4:44 PM, the DON confirmed Resident #37 did not have a safety assessment for the use of side rails and an informed consent to include the risks and benefits of side rails obtained prior to the installation of the side rails. The facility policy titled Proper Use of Side Rails, dated 12/2016, documented an assessment of the resident was made and included the device to be used, cognitive status, physical status, a review of whether the resident had the potential to become entrapped or harmed, and risk factors associated with use of the device. The resident was reevaluated quarterly and as needed with significant changes for safety relative to side rail use. The facility assessed the space between the mattress and side rails to reduce the risk of entrapment. The amount of safe space varied depending on the type of bed and mattress being used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Fallon Rehabilitation LLC	550 North Sherman Street Fallon, NV 89406

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34524 Based on interview and document review, the facility failed to ensure there were eight hours of consecutive Registered Nurse (RN) coverage for 6 of 90 days reviewed for staffing. This deficient practice could have allowed all 87 residents residing in the facility on the affected dates to go without proper assessments or certain cares RNs can perform. Findings include: Review of the facility Daily Nursing Staff Posting and Census sheets revealed the following: - No RN coverage on 06/02/2024 - No RN coverage on 06/14/2024 - No RN coverage on 06/18/2024 - No RN coverage on 06/19/2024 - No RN coverage on 06/24/2024 - No RN coverage on 08/17/2024 On 08/22/2024 at 1:31 PM, the Director of Nursing (DON) verbalized there was no RN coverage on 06/02/2024, 6/14/2024, 6/18/2024, 6/19/2024, 6/24/2024, and 8/17/2024. The DON confirmed the facility did not meet the requirement for eight consecutive hours of RN coverage on the dates listed.

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46301 Based on interview and personnel record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had an annual performance evaluation completed timely for 1 of 2 CNAs employed greater than one year, sampled for personnel record review (Employee #8). Findings include: On 08/21/2024 at 2:29 PM, the Human Resources Manager and Regional Human Resources participated in an interview to confirm the accuracy of the Personnel Records Checklist completed by the facility for 18 employees. Employee #8 Employee #8 was hired as a CNA with a start date of 02/07/2023. Employee #8's personnel record documented the CNA had an annual performance evaluation completed on 08/19/2024. On 08/21/2024 at 2:54 PM, the Business Office Manager provided Employee #8's date of last performance evaluation dated 08/19/2024. The Business Office Manager was unable to provide evidence the CNA had an annual performance evaluation completed by 02/07/2024. The Business Office Manager confirmed the CNA annual performance evaluation was completed late. The facility policy titled Annual Performance Evaluation for Certified Nursing Assistants, undated, documented performance evaluations were completed for each CNA under their supervision on an annual basis.

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NAME OF PROVIDER OR SUPPLIER: Highland Manor of Fallon Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 550 North Sherman Street Fallon, NV 89406	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 1) Controlled Drug Records (CDR) were correctly completed for 1 of 3 inspected medication carts to reflect an accurate reconciliation of controlled medications for 2 of 19 sampled residents (Resident #4 and #74), and 2) ordered medications were available and administered for 2 of 19 sampled residents (Resident #79 and #40). Findings include: Controlled Drug Records Resident # 4 Resident #4 was admitted to the facility on [DATE], with diagnoses including chronic pain syndrome, rash and other nonspecific skin eruption, and opioid dependence, uncomplicated. A physician's order dated 08/14/2024, documented oxycodone hydrochloride (HCl) 10 milligram (mg) tablets. Give one and a half tablets by mouth every four hours as needed for pain related to chronic pain syndrome. On 08/21/2024 at 3:39 PM, the label on a medication dispensing card (medication card) contained oxycodone HCl 10 mg tablets and documented to give Resident #4 one tablet by mouth every four hours as needed for pain. The medication card was empty. The corresponding CDR documented the following: -On 08/20/2024 at 11:41 PM, one tablet was administered, and five tablets remained available -On 08/21/2024 at 5:20 PM, one and a half tablets were administered, and a half tablet was wasted. Three tablets remained available. -On 08/21/2024 at 9:30 AM, 1.5 tablets were administered, and the balance remaining was not legible. The signature line was left blank. -On 08/21/2024 at 9:30 AM, a half tablet was wasted. The signature line documented the word waste but was left unsigned. The balance remaining was documented as one and a half tablets. -The next line, labeled line 25, did not document a date or time, the column labeled amount documented a half tablet, the signature line appeared to have the word waste written in and then scribbled out, the balance remaining box was left empty. -Line 26 did not document the date, time, amount of medication or a signature. The amount remaining box documented one tablet remained available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Line 27 did not document the date, time, amount of medication or a signature. The amount remaining box documented zero tablets remained available. On 08/21/2024 at 3:40 PM, a Registered Nurse (RN1) confirmed Resident #4's physician orders for oxycodone HCl instructed to give one and a half tablets and did not match the label on the medication dispensing card. RN1 explained nurses had to cut one tablet in half to be administered and the other half of the tablet had to be wasted. On 08/21/2024 at 3:42 PM, the Director on Nursing (DON) verbalized the inconsistent practice for wasting the remaining medication, the missing components of documentation on the CDR, and the incorrect instructions on the medication card's label caused concerns related to the potential for diversion of the medication. The DON confirmed the remaining half tablet of the medication was not being consistently wasted indicating the remaining half tablet was being saved and administered at a later time. This practice created the risk for the medication to become loose and float around in the medication cart. The DON confirmed the label on medication containers, including medication cards, should always match the physician's order. 08/21/2024 at 3:50 PM, a medication cup containing one half of a small, white, round pill was found in the medication cart's controlled substance drawer. The RN explained the half tablet was oxycodone HCl 10 mg tablet belonging to Resident #4 and had been placed in the cup to be wasted at a later time. The RN confirmed documentation on Resident #4's CDR had not been completely and thoroughly completed and was incorrect. The RN verbalized the expectation was controlled substances would be documented on the CDR at the time of administration and/or when the medication was wasted. The facility policy titled Medication Labeling and Storage, revised 02/2023, documented labeling of medications dispensed by the pharmacy was consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. Only the dispensing pharmacy could label or alter the label on a medication container or package. Nursing staff were required to inform the pharmacy when medication labels were missing, incomplete, or had improper or incorrect labels. Cross reference with F761 Resident # 74 Resident #74 was admitted to the facility on [DATE], and readmitted on [DATE], with paranoid schizophrenia, adjustment disorder with mixed anxiety and depressed mood, rheumatoid arthritis, pain, unspecified, and other chronic pain. A physician's order dated 06/20/2024, documented Ativan (lorazepam) 0.5 mg tablets, give one tablet by mouth three times per day for anxiety. On 08/21/2024 at 4:07 PM, Resident #74's CDR for lorazepam 0.5 mg tablets documented 19 tablets should have been remaining. There were 18 tablets of the medication remaining on the corresponding medication card. On 08/21/2024 at 4:11 PM, the DON confirmed the CDR count and the actual amount of Ativan remaining did not match. The DON explained Resident #74 had extreme anxiety and missed doses of Ativan could cause the resident undue stress. (continued on next page)

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A physician's order dated 08/19/2024, documented oxycodone HCl 10 mg tablets, give one tablet by mouth two times per day related to other chronic pain.

On 08/21/2024 at 4:18 pm, Resident #74's CDR for oxycodone HCl 10 mg tablets, documented there were 30 tablets remaining. There were only 28 tablets available on the corresponding medication card.

On 08/21/2024 at 4:20 PM, the DON confirmed Resident #74's CDR and the actual amount of medication remaining on the corresponding medication card did not match. The DON explained there was a concern for diversion when medications could not be reconciled correctly.

34524

Resident #79

Resident #79 was admitted to the facility on [DATE], with diagnoses including effusion, right knee and pain, unspecified.

On 08/19/2024 at 3:00 PM, Resident #79 verbalized the resident has 10 out of 10 knee pain and takes pain medications and Lidocaine patches to manage the pain. The resident explained the facility ran out of Lidocaine patches and the resident went without for a couple of weeks.

A physician order dated 06/10/2024, documented Lidocaine external patch 4 percent (%), apply to right knee topically one time a day related to pain, unspecified.

On 08/21/2024 at 2:42 PM, a Licensed Practical Nurse (LPN1) verbalized Resident #79 received pain medication, Voltaren gel, and Lidocaine patches for knee pain. The LPN explained the facility had been out of Lidocaine patches recently and the resident was not able to receive them during the time the facility did not have them in the building.

On 08/22/2024 at 9:24 AM, LPN2 verbalized the facility had been out of lidocaine patches. LPN2 explained the patches were over the counter and were not provided by the pharmacy.

An Orders-Administration Note dated 07/19/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Unavailable, on order with supply.

An Orders-Administration Note dated 07/20/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Unavailable, pending pharmacy, MD notified.

An Orders-Administration Note dated 07/22/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. No patches available, on order.

An Orders-Administration Note dated 07/23/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. No patches available.

An Orders-Administration Note dated 07/26/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. On order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Orders-Administration Note dated 07/27/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Out of stock, on order. An Orders-Administration Note dated 07/28/2024, documented Lidocaine patch, apply to knee topically one time a day related to pain. Medication on order with medline, not available in e-kit. MD notified. On 08/22/2024 at 9:29 AM, the DON verbalized the facility was out of lidocaine patches for a period of time due to a lost shipment. The DON confirmed the resident did not receive the lidocaine patches as ordered. The DON explained the Lidocaine patches could be purchased over the counter and the facility should have gotten some for the resident and did not. 50210 Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic atrial fibrillation unspecified, constipation unspecified, and primary hyperparathyroidism. Apixaban A physician's order dated 07/12/2024, documented Apixaban oral tablet 5 mg. Give one tablet by mouth two times a day for chronic atrial fibrillation. Resident #40's August Medication Administration Record (MAR) documented a nine for Apixaban administration on 08/08/2024 during morning medication pass. The MAR chart code documented a nine indicated other, see progress notes. A progress note dated 08/08/2024 at 8:46 PM, documented Apixaban oral tablet 5 mg. Give one tablet by mouth two times a day for chronic atrial fibrillation. Medication unavailable, pending pharmacy, MD notified. Cinacalcet A physician's order dated 06/28/2024, documented Cinacalcet Hydrochloride (HCl) oral tablet 30 mg. Give one tablet by mouth two times a day for hyperparathyroidism. Resident #40's July MAR documented nines for Cinacalcet HCl administration on the following dates during night medication pass: -On 07/04/2024 -On 07/05/2024 Resident #40's August MAR documented a nine for Cinacalcet administration on 08/07/2024 during morning medication pass. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40's progress notes documented the following: -Effective date 07/04/2024, Cinacalcet HCl oral tablet 30 mg. Give one tablet by mouth two times a day for hyperparathyroidism. Medication pending pharmacy, pharmacy notified. -Effective date 07/05/2024, Cinacalcet HCl oral tablet 30 mg. Give one tablet by mouth two times a day for hyperparathyroidism. Pending pharmacy. -Effective date 08/07/2024, Cinacalcet HCl oral tablet 30 mg. Give one tablet by mouth two times a day for hyperparathyroidism. On order. Polyethylene Glycol A physician's order dated 06/28/2024, documented Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Resident #40's August MAR documented nines for Polyethylene Glycol administration on the following dates: -On 08/01/2024 at noon medication administration pass. -On 08/01/2024 at night medication administration pass. -On 08/02/2024 at morning medication administration pass. -On 08/02/2024 at noon medication administration pass. -On 08/02/2024 at night medication administration pass. -On 08/03/2024 at morning medication administration pass. -On 08/03/2024 at noon medication administration pass. -On 08/03/2024 at night medication administration pass. -On 08/04/2024 at morning medication administration pass. -On 08/04/2024 at noon medication administration pass. -On 08/05/2024 at morning medication administration pass. Resident #40's Progress Notes documented the following: -Effective date 08/01/2024 at 12:15 PM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Medication on order. -Effective date 08/01/2024 at 8:00 PM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Medication pending pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Effective date 08/02/2024 at 7:56 AM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. On order. -Effective date 08/02/2024 at 12:04 PM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. On order. -Effective date 08/02/2024 at 9:00 PM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Medication pending pharmacy. -Effective Date 08/03/2024 at 8:26 AM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Medication on order. -Effective date 08/03/2024 at 11:55 AM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. On order. -Effective date 08/03/2024 at 7:58 PM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Ordered. -Effective date 08/04/2024 at 9:50 AM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Medication unavailable. -Effective date 08/04/2024 at 12:44 PM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Facility out of medication. -Effective date 08/05/2024 at 9:00 AM, Polyethylene Glycol powder. Give 17 grams by mouth three times a day for constipation. Facility out of medication. Potassium Chloride A physician's order dated 07/03/2024, documented Potassium Chloride oral packet 20 milliequivalent (meq). Give 20 meq by mouth two times a day related to chronic atrial fibrillation unspecified. Resident #40's July MAR documented a nine for Potassium Chloride administration on 07/04/2024 during the morning pass. A Progress Note dated 07/04/2024 at 9:26 PM, documented Potassium Chloride oral packet 20 meq. Give 20 meq by mouth two times a day related to chronic atrial fibrillation unspecified. Drug unavailable. On 08/21/2024 at 10:59 AM, RN2 verbalized the RN ensured medications were on site by ordering from the pharmacy when 10 administrations remained. If no administrations remained, the RN would document in the progress notes and call the pharmacy. If a medication was not administered to a resident as a result of no remaining administrations, the RN would call the doctor, and document in the progress notes. RN2 verbalized a check mark on the MAR indicated the medication was administered but a nine on the MAR indicated other, see progress note. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN2 confirmed nines on Resident #40's July 2024 and August 2024 MARs for Apixaban, Cinacalcet HCl, Polyethylene Glycol, and Potassium Chloride on the above dates. The RN explained the risks for missed administrations of Apixaban included blood clots, Potassium Chloride included constipation and bowel obstruction, and Potassium Chloride included increased heart issues. The RN verbalized the DON was responsible for ensuring medications were available and on site. On 08/21/2024 at 10:59 AM, the DON explained the facility contracted pharmacy was out of state, so the facility did not receive same-day medication delivery and the facility was often worried about running out of medications. The DON expected nurses to reorder a medication with a pharmacy fax call report when there was a seven-day supply of medication remaining. If no administrations remained, the DON expected nurses to document and inform the doctor. The DON explained a nine on the MAR could indicate a resident was not given a medication and the nurse needed to do additional documentation. The DON Confirmed the nines on Resident #40's July 2024 and August 2024 MARs for Apixaban, Cinacalcet HCl, Polyethylene Glycol, and Potassium Chloride on the above dates. The DON confirmed Resident #40's progress notes correlated with the dates and times on the resident's MARs. The DON explained the risks for missed administrations of Apixaban included blood clots, Cinacalcet included multiple side effects, Potassium Chloride included bowel obstruction, and Potassium Chloride included out of balance electrolytes. The DON verbalized the pharmacy fax call reports would be in the Pharmacy Fax Call Report binder. On 08/21/2024 at 12:30 PM, the DON verbalized the July 2024and August 2024 pharmacy fax call reports for Resident #40 could not be found. The Use of Outside Pharmacy Agreement documented the facility assumed responsibility for obtaining pharmaceutical and consultation services by a licensed pharmacist that met professional standards and principals including timeliness of services. A facility policy titled, Medication Ordering Policy, undated, documented the facility nurse was responsible for contacting the pharmacy to place new medication orders or request refills as needed. For new orders, the nurse would confirm the order details and ensure the prescription was processed promptly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 1) a pharmacy label's instructions for administration on a medication dispensing card (medication card) matched the physician's order for1 of 19 sampled residents (Resident #4), 2) pre-poured medications were not stored unlabeled in a medication cart for 1 of 19 sampled residents (Resident #61), 3) expired medications were removed from one of three inspected medication carts, 4) insulin pens were correctly labeled and stored in medication carts, 5) medications requiring refrigeration were stored in a refrigerator, and 6) unlabeled and loose medications were not stored in medication carts. Findings include: Resident # 4 Resident #4 was admitted to the facility on [DATE], with diagnoses including chronic pain syndrome, rash and other nonspecific skin eruption, and opioid dependence, uncomplicated. A physician's order dated 08/14/2024, documented oxycodone hydrochloride (HCl) 10 milligram (mg) tablets. Give one and a half tablets by mouth every four hours as needed for pain related to chronic pain syndrome. On 08/21/2024 at 3:39 PM, the label on a medication card documented to give oxycodone HCl 10 mg tablets, one tablet by mouth every four hours as needed for pain. Documentation on the corresponding Controlled Drug Record (CDR) documented the remaining half tablet was wasted ** times when the medication was administered ** times, indicating the remaining half tablet was saved and administered with the next dose when it was not wasted. On 08/21/2024 at 3:40 PM, a Registered Nurse (RN) confirmed Resident #4's physician orders for oxycodone HCl instructed to give one and a half tablets and did not match the label on the medication card. The RN explained nurses had to cut one tablet in half to be administered and the other half of the tablet had to be wasted. On 08/21/2024 at 3:42 PM, the Director on Nursing (DON) verbalized the inconsistent practice for wasting the remaining medication, the missing components of documentation on the CDR, and the incorrect instructions on the medication card's label caused concern related to the potential for diversion of the medication. The DON confirmed the remaining half tablet of the medication was not being consistently wasted indicating the remaining half tablet was being saved and administered at a later time. This practice created the risk for the medication to become loose and float around in the medication cart. The DON confirmed the label on medication containers, including medication cards, should always match the physician's order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/2024 at 3:50 PM, a medication cup containing one half of a small, white, round pill was found in the medication cart's controlled substance drawer. The RN explained the half tablet was oxycodone HCl 10 mg tablet belonging to Resident #4 and had been placed in the cup to be wasted at a later time. The RN confirmed documentation on Resident #4's CDR had not been completely and thoroughly completed and was incorrect. The RN verbalized the expectation was controlled substances would be documented on the CDR at the time of administration and/or when the medication was wasted. The facility policy titled Medication Labeling and Storage, revised 02/2023, documented labeling of medications dispensed by the pharmacy was consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. Only the dispensing pharmacy could label or alter the label on a medication container or package. Nursing staff were required to inform the pharmacy when medication labels were missing, incomplete, or had improper or incorrect labels. Cross reference with F755 Resident #61 Resident #61 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dysarthria following cerebral infarction, type II diabetes mellitus without complications, unspecified dementia, unspecified, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and essential (primary) hypertension. A physician's order dated 06/27/2024, documented amlodipine besylate 10 mg tablets, give one tablet one time per day for hypertension. A physician's order dated 07/12/2024, documented carbamazepine 20 mg tablets, give one tablet by mouth one time per day for hypertension. A physician's order dated 07/12/2024, documented hydralazine HCl 50 mg tablets, give one tablet by mouth three times per day for hypertension. A physician's order dated 07/28/2024, documented Risperdal 0.5 mg tablets, give one tablet by mouth two times per day for dementia with verbal and physical behaviors. A physician's order dated 07/30/2024, documented clopidogrel bisulfate 75 mg tablets, give one tablet by mouth two times per day for agitation. Resident #61's Medication Administration Record (MAR) for August 2024, documented the above prescribed medications were scheduled to be administered during the morning of 08/22/2024. The MAR lacked documented evidence of a sixth tablet of medication to be administered with the residents morning medications. On 08/22/2024 at 8:27 AM, an RN returned to the 300 hall medication cart with a medication cup containing six tablets of medication. The nurse confirmed the medication cup contained six tablets and explained the medication belonged to Resident #61 and the resident had refused the medications. The RN wrote the resident's first name on the cup and placed the cup in a drawer of the medication cart to be administered at a later time. The RN confirmed this was the nurses usual practice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Highland Manor of Fallon Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 550 North Sherman Street Fallon, NV 89406	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/2024 at 9:54 AM, the medication cup labeled with the resident's first name and containing six tablets of medication was located in the drawer of the medication cart. The DON confirmed loose, and unlabeled medications should not be stored in medication carts for any length of time. The facility policy titled Medication Labeling and Storage, revised 02/2023, documented medications were stored in the packaging, containers, or other dispensing systems in which they were received. Nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Expired Medication On 08/22/2024 at 9:57 AM, during an inspection of the 300 hall medication cart with the DON, two 12 ounce bottles of Geri-Lanta, regular strength were found with the expiration date of 07/2024. On 08/22/2024 at 9:58 AM, the DON confirmed the medication had expired and should have been removed from the medication cart prior to expiration. The facility policy titled Medication Labeling and Storage, revised 02/2023, documented the pharmacy was contacted for instructions regarding the return or destruction of outdated medications. Insulin Pens On 08/22/2024, at 10:03 AM, two insulin pens and one glucagon-like peptide-1 (GLP-1) pen were located in the 300 hall medication cart. The pens belonged to three different residents and were being stored together, without separation, in a drawer of the medication cart. The pens did not have a pharmacy label. On 08/22/2024 at 10:04 AM, the DON confirmed insulin/GLP-1 pens should not be stored in the same cubby of the medication cart without a barrier to separate the pens. The DON explained storing the pens together without a separating barrier was an infection control concern and had the potential to result in a resident receiving an injection from a pen belonging to another resident. On 08/22/2024 at 10:50 AM, two insulin pens were located in the memory care unit's medication cart. The pens belonged to two different residents and were being stored together, without separation, in a drawer of the medication cart. The pens did not have a pharmacy label. The DON confirmed the pens belonged to two different residents and were being stored in a section of the medication cart without separation or barrier between the pens. The facility policy titled Medication Labeling and Storage, revised 02/2023 documented each resident's medications were assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Labeling of medications dispensed by the pharmacy was consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. At a minimum labels included the medication name, prescribed dose, strength, expiration dates as applicable, the resident's name, route of administration, and appropriate instructions and precautions. Refrigerated medications (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/2024 at 10:09 AM, one 30 milliliter (ml) bottle of Lorazepam Intensol (lorazepam) oral concentrate 2 mg/ml was located in the 300 hall medication cart. The label on the medications packaging documented the medication was to be stored at a temperature between 36-46 degrees Fahrenheit (F). On 08/22/2024 at 10:15 AM, the DON confirmed the 30 ml bottle of lorazepam stored in the 300 hall medication cart should not have been stored unrefrigerated in the medication cart and should have been stored in the medication refrigerator. The DON explained storing the medication in the medication cart, and not in the refrigerator, had the potential to change the concentration of the medication, resulting in the resident receiving a wrong/stronger dose, resulting in the resident becoming over sedated. The manufacturer's insert for Lorazepam Intensol (lorazepam) last revised on 01/2023, documented lorazepam was to be stored at a cold temperature. Refrigerate at 36-46 degrees F and protect from light. The facility policy titled Medication Labeling and Storage, revised 02/2023 documented medications requiring refrigeration were stored in a refrigerator located in the medication room at the nurse's station or other secured location. Loose and Unlabeled Medications On 08/22/2024 at 10:39 AM, during an inspection of the Memory Care Unit's medication cart, conducted with the DON, a large plastic baggie containing 5 bottles of medication was located. One of the five bottles of medication had a faded label and could not be read. There were five large, white, round pills loose in the bottom of the baggie. The loose medication could not be identified. On 08/22/2024 at 10:46 AM, the DON verbalized when a label was faded and could not be read, the expectation was the pharmacy would be notified to replace the medication for resident safety. The DON confirmed medications should not be kept loose in medication carts and explained when medications were kept loose and/or in unlabeled containers one would not know what the medication was, where it came from, the expiration date or other pertinent information. The facility policy titled Medication Labeling and Storage, revised 02/2023 documented labeling of medications dispensed by the pharmacy was consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. Only the dispensing pharmacy could label or alter the label on a medication container or package. Nursing staff were required to inform the pharmacy when medication labels were missing, incomplete, or had improper or incorrect labels.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident was provided dental services timely related to damaged dentures for 1 of 19 sampled residents (Resident #27). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], with a diagnosis of moderate protein-calorie malnutrition. Nursing Progress Notes dated 07/18/2024, documented the following: - At 1:28 PM, staff informed a nurse Resident #27's bottom dentures had been broken. The nurse entered the room to confirm, and the dentures were broken in half. - At 5:45 PM, staff noted Resident #27's bottom dentures were split in half. A Progress Note dated 08/06/2024 at 7:13 PM, documented Resident #27's lower dentures were broken in half. Until the dentures could be repaired, the nurse had downgraded the diet to mechanical soft. A physician's order dated 08/06/2024, documented regular diet, mechanical soft texture, thin liquids, level zero thin consistency (TN0), small portions. A Social Services Progress Note dated 08/16/2024 at 11:47 AM, documented Resident #27 presented with broken bottom dentures. Resident #27 refused to go to the dentist and requested the facility to buy denture glue and fix the dentures. A Nursing Progress Note dated 08/16/2024 at 12:23 PM, documented the hospice Social Worker visited Resident #27 and was assisting with dentist appointments to get the resident's broken dentures fixed. Resident #27's clinical record lacked documented evidence the facility attempted to get Resident #27's bottom dentures fixed between 07/18/2024, when the facility was first made aware, and 08/16/2024, when the facility was again presented with Resident #27's broken bottom dentures. On 08/19/2024 at 11:52 AM, Resident #27 did not have bottom dentures. On 08/19/2024 at 11:52 AM, Resident #27 verbalized approximately a month and a half prior, Resident #27's bottom dentures were knocked from the resident's hands by a staff member and the dentures broke in half. Resident #27 explained the resident still did not have denture replacements and was unsure whether an appointment was made to get the dentures fixed. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident verbalized the resident did not have bottom dentures because the facility broke them and was unable to chew food well enough to swallow. Resident #27 verbalized the facility informed Resident #27 the resident would be on a soup only diet, and the resident felt the resident was being forced to die faster than was natural as the resident was already on hospice and now could not eat solid food. On 08/20/2024 at 12:18 PM, Resident #27 was served lunch, which included ground meat. The lunch meal ticket for Resident #27 dated 08/20/2024, documented a mechanical soft diet. On 08/20/2024 at 3:23 PM, the Van Driver/Certified Nursing Assistant (CNA) verbalized if a resident broke their dentures, the CNA would make an appointment to fix the dentures and inform the social worker who would then document progress. The CNA recalled when Resident #27's dentures broke, the Social Worker gave the dentures to the Resident Advocate on 08/16/2024, who attempted to make a dental appointment. On 08/21/2024 at 3:43 PM, the Resident Advocate (RA) explained if a resident broke their dentures, the RA would collaborate with transportation to make a dentist appointment. The RA verbalized on 08/16/2024, an aide informed the RA Resident #27's dentures broke, the hospice Social Worker brought the RA the broken dentures, and the RA spoke with the resident about making a dentist appointment. The RA confirmed the progress notes on 07/18/2024, and verbalized the progress notes were the only documentation the facility had on Resident #27's broken dentures. The RA was unable to confirm whether the facility was addressing Resident #27's broken dentures between 07/18/2024, and 08/16/2024. The RA expressed being unsure what happened prior to the RA starting at the facility approximately two weeks ago in the resident advocate role. On 08/21/2024 at 4:06 PM, the Administrator verbalized the person previously in the RA position had no follow through, so the facility gave the position to the current RA. The Administrator explained when the previous RA left, a lot of the documentation left with them. The facility policy titled Dental Services, undated, documented lost or damaged dentures would be replaced at the resident's expense unless an employee or contractor of the facility was responsible for damaging the dentures. If dentures were damaged or lost, residents would be referred for dental services within three days. If the referral was not made within three days, documentation would be provided regarding what was being done to ensure the resident was able to eat and drink adequately while awaiting dental services; and the reason for the delay. All dental services provided would be recorded in the resident's medical record.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, observation, clinical record review, and document review, the facility failed to honor a resident's meal preferences for a vegetarian diet and provide a meat substitute for meat entrees for 1 of 19 sampled residents (Resident #40). This deficient practice had the potential to deprive the resident of equal nutritional value for a preference of a vegetarian diet. Findings include: Resident #40 Resident #40 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of metabolic encephalopathy. A Progress Note dated 07/04/2024, documented the resident wanted a vegetarian diet. On 08/19/2024 at 3:19 PM, Resident #40 verbalized the facility did not have a vegetarian menu. The lunch menu for 08/20/2024, documented barbeque beef ribs. On 08/20/2024 at 12:19 PM, Resident #40 was served lunch, which included beef. On 08/20/2024 at 12:19 PM, the Certified Nursing Assistant (CNA1) confirmed beef was served on Resident #40's plate. On 08/20/2024 at 3:19 PM, the CNA2 verbalized if a resident told the CNA2 the resident was vegetarian, the CNA2 would inform the kitchen and the preference should be documented in the resident's care plan and restaurant profile. The CNA2 verbalized Resident #40 was vegetarian. The lunch menu for 08/21/2024, documented hamburger steak with gravy. On 08/21/2024 at 12:21 PM, Resident #40 was served lunch, which included a meat with gravy. The lunch meal ticket for Resident #40 dated 08/21/2024, documented a regular diet, regular texture. No preferences were documented. On 08/21/2024 at 12:25 PM, Resident #40 confirmed there was meat for lunch and verbalized the resident did not eat meat. On 08/21/2024 at 4:30 PM, a Registered Nurse (RN) verbalized if a resident told the RN the resident was vegetarian, the RN would notify the kitchen. The RN did not think Resident #40 was vegetarian. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 4:34 PM, the Dietary Manager (DM) verbalized when a resident was admitted to the facility, the DM would receive a diet slip with orders and would sometimes ask residents about their preferences. The DM explained the facility did not have a vegetarian menu, a vegetarian resident would receive the day's menu without the meat, and Resident #40 was vegetarian so should have received the lunch without meat. The DM verbalized the DM was informed Resident #40 was vegetarian approximately three weeks prior and was unaware Resident #40 was served meat on 08/20/2024, and 08/21/2024, which should not have occurred. The DM explained Resident #40's meal ticket for 08/21/2024 did not document the resident was vegetarian because vegetarian preferences were not on Resident #40's care plan. The DM verbalized if vegetarian preferences were care planned, vegetarian preferences should be on the meal ticket. Resident #40's care plan included a focus revised 08/18/2024, documented a concern related to nutrition. An intervention initiated 07/10/2024 by the facility's Registered Dietician, documented Resident #40 preferred vegetarian and to provide food preferences. The facility policy titled Food Service, revised 09/2010, documented the facility would provide residents with a liberalized diet based on a regular diet and offer the resident choices. The regular diet would include five and a half to six ounces of meat, fish, poultry, eggs, or a meat substitute.

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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** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure the administration of physician ordered nutritional shakes (Ensure) was documented for 1 of 19 sampled residents (Resident #27). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], with a diagnosis of moderate protein-calorie malnutrition. A physician's order dated 08/06/2024 documented chocolate Ensure. May leave two at bedside per patient request one time a day. Resident #27's August 2024 Medication Administration Record (MAR) documented chocolate Ensure. May leave two at bedside per patient request one time a day, scheduled to be administered during the morning medication pass. The MAR had blank spaces for Ensure administration on 08/16/2024, 08/19/2024, and 08/20/2024. Resident #27's clinical record lacked documented evidence the Ensures were administered on 08/16/2024, 08/19/2024, and 08/20/2024. On 08/22/2024 at 11:32 AM, a License Practical Nurse (LPN) clarified Resident #27's physician order for chocolate Ensures as a scheduled medication the resident should receive every day. The LPN confirmed the blank spaces on the MAR for 08/16/2024, 08/19/2024, and 08/20/2024, and the LPN explained the blank spaces could mean the administering nurse forgot to document administration or the resident was not given the prescribed Ensures. If the Ensures were not given, the LPN explained the administering nurse should have documented on the MAR and in progress notes to explain why the Ensures were not given. On 08/22/2024 at 12:55 PM, the Director of Nursing (DON) verbalized a blank space on the MAR meant administration was not documented, so the medication was not given. The DON explained if a medication was not administered, it should be documented on the MAR and in progress notes. The DON explained if a medication was administered, it should be documented on the MAR to avoid duplicate administrations. The DON verbalized the physician's order for the Ensures should have been verified with the doctor due to poor wording, but confirmed the order was scheduled for the resident to receive Ensures one time a day during the morning medication pass. The DON confirmed the blank spaces on the MAR for Ensure administrations on 08/16/2024, 08/19/2024, and 08/20/2024. The facility policy titled Administering Medications, revised 04/2019, documented the individual administering the medications were to initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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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. 43310 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 medications were correctly labeled and stored, and controlled substances were accurately documented and reconciled. Findings include: On 08/22/2024 at 2:14 PM, the Regional [NAME] President confirmed the facility had not identified a concern related to labeling and storage of medications, and reconciliation of controlled substances. The Regional [NAME] President verbalized the facility could have become aware of the concern by completing audits of medication storage areas and performing reconciliation of controlled substances. A facility policy titled Quality Assurance and Performance Improvement (QAPI) Plan, revised 04/2014, documented the QAPI plan designed to monitor and evaluate the quality and safety of resident care and pursue methods to improve care quality, and resolve identified problems. Cross reference with F755 and F761

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43310 Based on interview, and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee held meetings quarterly at a minimum. This failure had the potential to result in the facility not identifying and addressing concerns related to the quality of care in all areas of the facility. Findings include: The QAPI sign in sheets documented all required committee members were in attendance during the 4th quarter 2023, with the last meeting held on 09/20/2023. The facility lacked documented evidence of a meeting being held from January 2024 through June 2024. On 08/22/2024 at 1:56 PM, the Administrator verbalized the committee would meet as often as needed and at a minimum quarterly. The Administrator confirmed the facility could not provide documented evidence a QAPI meeting was held from January 2024 through June 2024. The facility policy titled Quality Assurance and Performance Improvement (QAPI) Plan, revised 04/2014, documented the QAPI Committee met monthly to review reports evaluate the significance of data, and monitor quality related activities of all departments, services, or committees.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41848

Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) the facility had a surveillance plan for identifying and tracking all infections in the facility. This deficient practice had the potential to result in the unmitigated spread of infections within the facility, 2) staff providing wound care to a resident on Enhanced Barrier Precautions (EBP) wore the appropriate Personal Protective Equipment (PPE) for 1 of 19 sampled residents (Resident #52), 3) staff changing a resident's ileostomy bag donned gloves and washed hands for 1 of 19 sampled residents (Resident #134), and 4) to ensure a resident's humidifier attached to the oxygen concentrator was not placed on the ground for 1 of 19 sampled residents (Resident #32).

Findings include:

On 08/21/2024 at 3:42 PM, the Infection Preventionist (IP) provided an infection surveillance binder. The binder included a listing, by month, of all residents receiving an antibiotic to treat a bacterial infection within the past year. The surveillance binder lacked any documentation of viral infections.

On 08/22/2024 at 12:53 PM, the IP verbalized the IP tracked infections within the facility by documenting the type of infection and tracking the location of infections on a facility map. The IP confirmed the IP was only tracking infections requiring treatment with an antibiotic. The IP verbalized staff and residents had tested positive for COVID-19 as recently as April 2024. The IP confirmed the IP had not included cases of COVID-19 in the infection surveillance documentation.

The facility policy titled Infection Prevention and Control Program, revised 07/2016, documented surveillance tools would be used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, and detecting unusual pathogens with infection control implications. Data gathered during surveillance was used to oversee infections and spot trends.

43310

Resident #52

Resident #52 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, type II diabetes mellitus with diabetic nephropathy, and personal history of methicillin resistant staphylococcus aureus (MRSA) infection.

A physician's order dated 04/24/2024, documented to place Resident #52 in EBP due to a history of MRSA in a wound.

On 08/20/2024 at 1:43 PM, a Licensed Practical Nurse (LPN)/Wound Care explained Resident #52 had wounds including an area of Moisture Associated Skin Damage (MASD) and a stage II pressure injury (PI) on the sacrum. The wound had progressed and appeared to be a [NAME] Ulcer.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/20/2024 at 1:49 PM, a physician assessed Resident #52's wounds and per the LPN Wound Care Nurse, agreed the wound had progressed into a [NAME] Ulcer and approved a change in wound care orders. On 08/20/2024 at 1:51 PM, a Certified Nursing Assistant, (CNA) was at Resident #52's bedside to assist with wound care. The dressing to Resident #52's sacrum had been removed and the CNA had assisted the resident to the residents left side for wound care. The CNA was not wearing a gown. The LPN/ Wound Care Nurse donned gloves, but did not wear a gown at any point during the provision of wound care. The LPN/Wound Care Nurse described the wound as an oval wing shaped wound to the sacrum/buttocks. The wound was approximately 10 centimeters (cm) long x 10 cm wide. The wound bed was red and shallow, approx. 0.5 cm deep. On 08/20/2024 at 2:01 PM, the wound care nurse confirmed the CNA, and the LPN/Wound Care Nurse did not wear gowns at any time during the provision of wound care to Resident #52. The LPN/Wound Care Nurse explained the nurse did not believe a gown was required unless high contact care was being provided and did not see the dressing change as high contact care. The nurse reviewed the signage posted on the residents door and after review acknowledged gowns should have been worn for wound care per the instructions on the sign. The LPN/Wound Care Nurse verbalized the nurse did not wear gowns for all wound care. On 08/21/2024 at 10:37 AM, the DON confirmed residents requiring wound care were placed on EBP and when close contact care was provided staff were expected to wear a gown and gloves. Close contact care included wound care, peri-care and bathing. The DON confirmed the LPN/Wound Care Nurse and the CNA should have worn gloves and gowns at all times while providing wound care for Resident #52. On 08/21/2024 at 8:11 AM, the Regional Clinical Resource verbalized the facility had been using EBP since April, but did not have a policy specific to EBP. The Regional Clinical Resource explained the facility followed Center for Disease Control and Prevention (CDC) guidance related to Transmission Based Precautions (TBP) needs, including EBPs. The facility provided a copy of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety, and Oversight (QSO) 24-08-NH guidance with the subject title Enhanced Barrier Precautions in Nursing Homes. The CMS QSO memo titled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, reference number 24-08-NH, documented in 2019, the CDC introduced a new approach to the use of PPE called Enhanced Barrier Precautions as a strategy in nursing homes to decrease transmission Multi Drug Resistant Organisms (MDROs). The approach recommended gown and glove use during specific high contact resident care activities associated with MDRO transmission. EBPs were indicated for residents with wounds, even if the resident was not known to be infected with an MDRO. Wounds generally included chronic wounds including but not limited to pressure injuries. EBP was employed when performing high-contact resident care activities including the provision of wound care for any skin opening requiring a dressing. 30748 Ileostomy Resident #134 (continued on next page)

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #134 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses included colostomy status and hypo-osmolality and hyponatremia. On 08/19/2024 at 11:13 AM, Resident #134 verbalized having an ileostomy and staff were coming in to check on the ileostomy at least two times per day. The resident could change the ileostomy bag by themselves, however staff were changing the bag most times. On 08/19/2024 at 11:18 AM, a CNA entered Resident #134's room to check on the resident's ileostomy bag. The CNA determined the ileostomy bag needed to be changed and removed the ileostomy bag from the wafer without donning gloves. The CNA went to the bathroom located in the resident's room, did not wash hands and exited the bathroom with an empty ileostomy bag and reapplied the ileostomy bag. The CNA confirmed not donning gloves prior to changing the resident's ileostomy bag, could not verbalize if the CNA washed hands, and verbalized not being required to don gloves while changing the ileostomy bag. On 08/19/2024 at 12:11 PM, the CNA verbalized following up with another staff member to see if Personal Protective Equipment (PPE), such as donning gloves, was required for changing the ileostomy bag and explained the CNA was not required to don gloves unless the resident had MRSA or something like that. On 08/20/2024 at 1:23 PM, the DON explained if staff were providing close contact care with a resident, such as changing an ileostomy bag, the staff would be required to don gloves. The DON verbalized if staff were not wearing gloves, the staff member and/or the resident could get an infection from the stool. The facility policy titled Colostomy/Ileostomy Care, last revised October 2010, documented staff were to wash and dry hands thoroughly, don gloves, and remove the drainage bag. Once the drainage bag was cleaned and back in place on the resident, the staff were to doff the gloves and wash hands with soap and water. Oxygen Humidifier Resident #32 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. 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 and the concentrator was turned on, while the resident was not getting Oxygen administered via the concentrator and the humidifier was lying on the ground. On 08/19/2024 at 11:11 AM, a Certified Nursing Assistant (CNA) confirmed the oxygen concentrator humidifier was lying on the ground and verbalized the humidifier lying on the ground was unsanitary, however was not sure if the humidifier on the ground would affect him at all. (continued on next page)

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	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Fallon Rehabilitation LLC	550 North Sherman Street Fallon, NV 89406

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/20/2024 at 10:57 AM, a Licensed Practical Nurse (LPN) explained staff were to check for placement of the humidifier each time staff entered the resident's room. The humidifier was supposed to be placed on the Oxygen concentrator and if the humidifier was found on the floor, it was an infection control concern. The humidifier was used to keep the resident's mucous membranes moist to avoid a bloody nose. On 08/20/2024 at 11:16 AM, the DON explained the purpose of the humidifier was to put moisture into the resident's nose for comfort. The ground was very dirty and if the humidifier was lying on the ground, it could compromise the resident's health. The DON verbalized the resident was autoimmune compromised and the tainted Oxygen would be administered to the resident's lungs and could potentially cause additional breathing problems for the resident. The facility policy titled Oxygen Administration, last revised October 2010, documented staff were to check the humidifying jar to be sure it was in good working order and securely fastened.