STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295096	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Reno	961 Kuenzli Street Reno, NV 89502

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and document review, the facility failed to ensure the Baseline Care Plan for 1 of 12 sampled residents (Resident #30) included monitoring and care instructions for an indwelling drainage tube. This deficient practice had the potential to result in the resident not receiving the care and services necessary to manage the drainage device. Findings include: Resident #30 Resident #30 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the circulatory system - cholecystostomy and calculus of gallbladder with other cholecystitis without obstruction. On 11/17/2025 at 2:17 PM, Resident #30 had a drainage bag sitting next to the resident, on the resident's chair. The tubing drain insertion site appeared to be in the resident's right upper quadrant (RUQ) and the drainage bag contained a small amount of dark brown/green drainage. The resident was not aware of what the drainage bag was for. A hospital Discharge summary dated [DATE], documented Resident #30 had a distended gall bladder with severe inflammation and a cholecystostomy tube (a biliary drainage tube) had been placed on 11/04/2025. A Physician Order Report documented the following orders entered on 11/07/2025: -Biliary, empty drain and record the amount, every shift. -Cleanse biliary drain site with normal saline and cover with a Tegaderm dressing daily, monitor for signs and symptoms of infection as needed. Resident #30's Baseline Care Plan, initiated on 11/06/2025, did not include a care plan for the monitoring and care of the resident's biliary drainage tube. On 11/20/2025 at 12:21 PM, the Director of Nursing (DON) confirmed Resident #30's Baseline Care Plan did not include a care plan related to the care and monitoring of the resident's biliary drainage device. The DON verbalized the importance of a care plan for an indwelling device was related to the risk for infection and explained the biliary drain was part of the reason the resident was at the facility. The care plan would have included management of the device and the insertion site, general care such as draining the device, measuring and documenting the amount and characteristics of the output, and instructions what to do if there were issues with the drain or signs and symptoms of an infection. On 11/20/2025 at 12:27 PM, the DON verbalized the baseline care plan was also important to ensure Certified Nursing Assistants (CNAs) were instructed to be aware of the drainage device during transfers and to ensure care was provided in a manner to reduce risk of infection. On 11/20/2025 at 4:30 PM, the facility had not provided the requested care plan policy.

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

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

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(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** Based on observation, clinical record review, interview and document review, the facility failed to ensure the Comprehensive Care Plan included a care plan for the monitoring and care of an indwelling drainage tube for 1 of 12 sampled residents (Resident # 30), and for the administration and monitoring of insulin for 1 of 12 sampled residents (Resident #9). This deficient practice had the potential to result in the residents not receiving the care and services necessary to manage the affected care areas. Findings include: Resident #30Resident #30 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the circulatory system - cholecystostomy and calculus of gallbladder with other cholecystitis without obstruction. On 11/17/2025 at 2:17 PM, Resident #30 had a drainage bag sitting next to the resident, on the resident's chair. The tubing drain insertion site appeared to be in the resident's right upper quadrant (RUQ) and the drainage bag contained a small amount of dark brown/green drainage. The resident was not aware of what the drainage bag was for. A hospital Discharge summary dated [DATE], documented Resident #30 had a distended gall bladder with severe inflammation and a cholecystostomy tube (a biliary drainage tube) had been placed on 11/04/2025. A Physician Order Report documented the following orders were entered on 11/07/2025: -Biliary, empty drain and record the amount, every shift. -Cleanse biliary drain site with normal saline and cover with a Tegaderm dressing daily, monitor for signs and symptoms of infection as needed.Resident #30's Comprehensive Care Plan did not include a care plan related to the monitoring and care of the resident's biliary drainage tube. On 11/20/2025 at 12:21 PM, the Director of Nursing (DON) confirmed Resident #30's Comprehensive Care Plan did not include a care plan related to the care and monitoring of the resident's biliary drainage device. The DON verbalized the importance of a care plan for an indwelling device was related to the risk for infection and explained the biliary drain was part of the reason the resident was at the facility. The care plan would have included management of the device and the insertion site, general care such as draining the tubing, measuring and documenting the amount and characteristics of the output, and instructions what to do if there were issues with the drain or signs and symptoms of an infection.Resident #9 Resident #9 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with other complications. Resident #9's Physician Order Summary documented the following orders dated 10/30/2025:- Insulin degludec insulin pen, 100 units/milliliters (ml), give 20 units subcutaneous, daily. Special instructions: DM II, hold for blood sugars less than 150. -Lispro insulin pen 100 units/ml, give per sliding scale, subcutaneous, at bedtime. -if blood sugar less than 50 call physician. -if blood sugar is 201-250, give 4 units. -if blood sugar is 251-300, give 6 units. -if blood sugar is 301-350, give 8 units. -if blood sugar is 351-400, give 10 units. -if blood sugar is over 400, call physician. Resident #9's Comprehensive Care Plan included a care plan for non-insulin dependent diabetes and did not include a care plan related to the use of insulin. On 11/20/2025 at 12:44 PM, the DON confirmed Resident #9 physician orders included orders for insulin. The DON confirmed Resident #9's Comprehensive Care Plan did not include a care plan related to the use and monitoring of insulin. On 11/20/2025 at 4:30 PM, the facility had not provided the requested care plan policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, document review, and interview, the facility failed to ensure medications were administered in a timely manner resulting in a medication error rate of 12%. This deficient practice had the potential to result in residents not receiving medications as prescribed, potentially compromising the effectiveness of treatment, and placing residents at risk for adverse health outcomes.Findings include: Resident #40Resident #40 was admitted to the facility on [DATE], with diagnoses including Parkinson disease without dyskinesia, without mention of fluctuations, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and multiple myeloma in remission. A Physician Order dated 11/04/2025, documented Carbidopa-levodopa 25-250 milligrams (mg) tablets, administer 3.75-375 mg by mouth four times per day. The morning dose was to be administered between 7:00 AM and 8:00 AM. A Physician Order dated 11/04/2025, documented gabapentin 300 mg capsules, administer 300 mg by mouth three times per day. The morning dose was to be administered between 6:00 AM and 8:00 AM. A Physician Order dated 11/18/2025, documented cyclobenzaprine 5 mg tablets, administer 5 mg by mouth three times per day. The morning dose was to be administered between 6:00 AM and 8:00 AM. On 11/20/2025 at 8:32 AM, a Registered Nurse (RN) administered medications, including cyclobenzaprine 5 mg tablet and carbidopa-levodopa 3.75-375 mg capsule to Resident #40. The medications were administered approximately 32 minutes late. The resident was on the resident's way to physical therapy at the time of medication administration and gabapentin was not available in the medication cart. The RN explained to the resident the medication would need to be retrieved from the medication room and brought to the resident in the physical therapy room. The medication was retrieved and administered to the resident appropriately 32 minutes late. On 11/20/2025 at 8:48 AM, the RN confirmed cyclobenzaprine, gabapentin, and carbidopa-levodopa, had been administered to Resident #40 over 30 minutes late. A facility policy titled Administration of Medication updated 05/05/2025, documented licensed personnel, in accordance with professional standards of practice appropriately administered prescribed medications. The procedure included verifying the six rights of medication administration, including the right time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, interview, and document review, the facility failed to ensure medications were stored according to the manufacturer's instructions in 1 of 2 inspected medication carts and failed to ensure medications were not left unattended on top of a medication cart. This deficient practice had the potential to result in medication contamination, diversion, or administration errors, placing residents at risk for receiving compromised or incorrect medications.Findings include: Storage of Medication On 11/19/2025 at 4:05 PM, during an inspection of the Hall Two medication cart with the Regional Nurse, a 30-milliliter (ml) bottle of lorazepam 2 milligrams (mg)/ml, with approximately 29 ml of liquid remaining in the bottle, was located in a drawer of the medication cart. A Registered Nurse (RN) confirmed lorazepam was traditionally stored in the medication carts and was not stored in a refrigerator after being opened. The manufacturer's label on the bottle of lorazepam instructed to store the medication at a temperature between 36-46 degrees Fahrenheit (F). On 11/19/2025 at 4:06 PM, the Regional Nurse confirmed the label on the bottle of lorazepam instructed to store the medication between 36-46 degrees F. A manufacturer's guide provided by the facility and distributed by Hikma Pharmaceuticals USA, INC. revised January 2023, documented to store lorazepam at cold temperature, refrigerate at 36-46 degrees F and protect from light. The medication guide documented the guide was approved by the United Stated Food and Drug Administration. Unattended Medication On 11/20/2025 at 8:32 AM, during a medication observation, an RN took a resident's medications to the physical therapy room to be administered to the resident. The RN left a lidocaine patch unattended on top of the medication cart and walked away. On 11/20/2025 at 8:42 AM, the RN returned to the medication cart and confirmed the nurse had left a lidocaine patch sitting unattended on top of the cart. The RN confirmed the medication should have been locked in the cart and should not have been left unattended. A facility policy titled Administration of Medication updated 05/05/2025, documented nurses were to lock the medication cart whenever the cart was out of view and medications were to be stored per manufacturer's guidelines. A facility policy titled Medication Storage updated 09/08/2022, documented medications were stored safely and securely following manufacturer's guidelines and all drugs and biologicals were stored in locked compartments under proper temperature controls. Medications requiring refrigeration or temperatures between 36-46 degrees F were stored in a refrigerator with a thermometer to allow temperatures to be monitored. Medications requiring storage in a cool place were refrigerated unless otherwise directed on the label.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure the thermometer used to take temperatures of food in holding trays was disinfected and sanitized between uses for each food item. The deficient practice had the potential to expose residents to foodborne illnesses due to cross-contamination.Findings include: On 11/19/2025 at 11:26 AM, the [NAME] was observed taking temperatures of the food to be served for lunch. However, the [NAME] did not clean and sanitize the thermometer between checking the temperature of each food to be served.On 11/19/2025 at 11:33 AM, the [NAME] explained the [NAME] takes temperatures of all food to be served to residents in the facility and in between taking temperatures of each food, the thermometer was to be disinfected and sanitized to prevent cross contamination of food. The [NAME] confirmed not disinfecting and sanitizing the thermometer in between taking temperatures of various foods to be served to residents and explained the [NAME] was trying to take temperatures quickly in the kitchen because of the survey in the kitchen.On 11/19/2025 at 11:55 AM, the [NAME] took a resident plate with pureed food on the plate from the holding oven. The [NAME] transferred the plate to the trayline and set the plate down. Next to the resident plate, was a thermometer resting on the trayline. The [NAME] took plastic wrap off of the resident plate, grabbed the thermometer, and put the thermometer in the food on the plate.On 11/19/2025 at 11:55 AM, the [NAME] denied not disinfecting and sanitizing the thermometer and verbalized the [NAME] could do the process over again.The facility policy titled Resource: Taking Accurate Temperatures, updated July 25, 2025, documented when taking hot food temperatures, read the temperature the food was registering and log the temperature in the food temperature logbook. Once completed, the thermometer must be immediately cleaned and sanitized prior to taking temperatures of another food.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review, the facility failed to ensure nursing services were provided in accordance with the facility's own assessment of resident needs and resources. This deficient practice had the potential to affect the delivery of care and services by direct care staff to the entire facility census, potentially compromising residents' health, safety and well-being. Findings include:A Facility Assessment (FA) reviewed with the Quality Assurance Performance Improvement (QAPI) Team dated 01/16/2025, documented the facility provided for resident support/care needs and considered both the census and acuity levels to staff the facility accordingly.The FA documented the direct care staff would be allocated to a day, evening, and night shift. Direct care staff was identified as Nurses and Certified Nursing Assistants (CNA).The Monday through Friday CNA staffing schedule was as follows:-Day Shift: 6:00 AM-2:00 PM= 5 CNAs, -Evening Shift: 2:00 PM-10:00 PM= 5 CNAs, -Night Shift: 10:00 PM-6:00 AM= 3 CNAsThe Saturday and Sunday CNA staffing schedule was as follows:-Day Shift: 6:00 AM-2:00 PM= 5 CNAs, -Evening Shift: 2:00 PM-10:00 PM= 5 CNAs, -Night Shift: 10:00 PM-6:00 AM= 3 CNAsThe Facility Resources section of the FA documented the facility considered both census and acuity levels that impacted staffing needs and staffed accordingly. The facility would not adjust staffing based on a fluctuation in census. Off-duty and as needed staff would be called in to provide additional support if the facility experienced an event requiring additional resources. The facility had the ability to use contracted temporary agency personnel for CNAs. The average daily census from the previous year was 41.5.The CNA staffing schedule for September 2025, documented the following:-Day shift: on 3 of 30 days there were fewer than 5 CNAs scheduled to work.-Evening shift: on 8 of 30 days there were fewer than 5 CNAs scheduled to work.The CNA staffing schedule for October 2025, documented the following:-Day shift: on 8 of 31 days there were fewer than 5 CNAs scheduled to work.-Evening shift: on 15 of 31 days there were fewer than 5 CNAs scheduled to work.-Night shift: on 1 of 31 days there were fewer than 3 CNAs scheduled to work.The CNA staffing schedule for November 2025, documented the following:-Evening shift: on 12 of 19 days there were fewer than 5 CNAs scheduled to work.-Night shift: on 2 of 19 days there were fewer than 3 CNAs scheduled to work.On 11/20/2025 at 2:03 PM, the Administrator confirmed the Administrator was responsible for the Facility Assessment. The Administrator explained the facility followed the annual FA after review by the QAPI committee. The facility was staffed by a combination of budget review process and coordination of care. The Administrator communicated the purpose of the FA was to allow the facility to take a step back and coordinate the type of services provided to the resident population and staff the facility accordingly. On 11/20/2025 at 2:08 PM, the Director of Nursing (DON) explained if staff called out on a shift, a call was made to full time and as needed staff for assistance with the shift. The management team would be expected to assist with resident care if the full time and/or as needed staff were unavailable. The DON confirmed there was a staffing contract in place to keep adequate patient care staffing but was not utilized in the months of September, October, and November 2025.The DON confirmed the accuracy of the provided staffing schedules for September, October, and November 2025.On 11/20/2025 at 2:11 PM, the Administrator confirmed the facility followed the FA for staffing needs. The Administrator explained when the staffing numbers did not reflect the FA the facility would either adjust the staffing model or adjust the FA according to facility population needs. The Administrator confirmed this was not documented and did not occur for the FA dated 01/01/2025 and reviewed on 01/16/2025. On 11/20/2025 at 2:17 PM, the DON explained the purpose of the FA was to identify and elaborate on the type of services related to resident care and staff accordingly. The October and November staffing reports reflected there was a CNA for each month who quit without notice and the facility had difficulty filling the position. The DON confirmed contracted staff was not utilized during CNA staffing difficulties.The facility policy titled Facility (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Tool, dated 01/10/2025, documented the purpose of the FA was to determine the resources necessary to competently care for residents during both day-to-day operations and emergencies. The assessment would help in making decisions about direct care staff needs, as well as the capabilities to provide services to the patients in the facility. The facility would conduct and document a facility-wide assessment to include both the patient population and the resources needed to provide resident care. The facility would review and update the assessment annually and when there was, or the facility planned for, any change requiring a substantial modification to any part of the assessment.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and document review, the facility failed to maintain the drainage pipe under a handwashing sink in the kitchen, allowing water to leak onto the kitchen floor. The deficient practice had the potential to pose a safety risk to staff working in the kitchen.Findings include:On 11/17/2025 at 8:26 AM, a handwashing sink in the kitchen was leaking water from a drainage pipe while an individual was washing hands. There was a water puddle under the sink, on the kitchen floor. On the drainage pipe below the sink, the pipe had duct tape wrapped around the pipe.On 11/17/2025 at 8:30 AM, the Kitchen Manager confirmed the handwashing sink pipes were leaking water onto the kitchen floor and explained the sink had been leaking for at least a few days. The Kitchen Manager explained the Kitchen Manager duct taped the pipe in hopes of preventing the pipe from leaking further onto the kitchen floor. The Kitchen Manager verbalized informing the Maintenance Director of the leaking pipe upon discovery and communicated the issue verbally.On 11/18/2025 at 8:30 AM, the Maintenance Director confirmed there was a handwashing sink in the kitchen that had a leak from the drainage pipe and verbalized being informed there was a leaking drainage pipe on the handwashing sink on 11/17/2025. The Maintenance Director explained if there was a concern with items in the facility needing maintenance, the staff would document the concern in the maintenance binder, and the Maintenance Director would have the issues fixed immediately. The Maintenance Director verbalized the maintenance binder was missing and had been missing for about a week.The facility policy titled Facility Maintenance Requests, undated, documented the facility would ensure maintenance issues identified would be reported and resolved in a timely manner to maintain a safe, functional, and compliant environment for residents, staff, and visitors. If a concern was identified, staff were to submit a maintenance request form in the maintenance logbook to include the location, date and time identified, requestors name, and a description of the issue. Maintenance requests would be evaluated and prioritized based on severity, risk to safety, and operational impact. If urgent or safety related maintenance concerns could not be fixed right away, the equipment would be tagged or blocked off to ensure those areas would not be used until the repairs were completed.