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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295103 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/21/2025 |
| NAME OF PROVIDER OR SUPPLIER Caremeridian Llc, Dba Neurorestorative | | STREET ADDRESS, CITY, STATE, ZIP CODE 3980 Lake Placid Drive Ste 2 Reno, NV 89511 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on interview, clinical record review, and document review the facility failed to ensure 1 of 12 sampled residents (Resident #17) was kept safe from neglect by a Respiratory Therapist (RT). This deficient practice had the potential for the resident to experience emotional and physical harm.</p> <p>Findings include:</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, disorders of diaphragm, dependence on respiratory (ventilator) status, and tracheostomy status.</p> <p>A Facility Reported Incident (FRI) initial and final report dated 11/05/2024, documented an allegation an RT did not provide physician ordered care to Resident #17. The concern was reported by the resident's family member on 10/30/2024. The allegation of neglect was substantiated by the facility.</p> <p>On 02/18/2025 at 4:10 PM, Resident #17's family member recalled a concern related to Resident #17 requiring transfer to and treatment in an intensive care unit (ICU) due to an RT's neglect. The family member recalled the incident happened not long after Resident #17 was admitted to the facility and the incident was reported to facility staff.</p> <p>A Physician's Order dated 10/23/2024, with a start date of 10/24/2024, documented Sprint order for two hours only at pressure support (P.S.) 12, peak expiratory pressure (Peep) 8. Spontaneous mode one time a day.</p> <p>On 02/20/2025 at 4:04 PM, the Respiratory Manager (RM) verbalized the facility's process if abuse or neglect was observed or an allegation was received, the staff member would report the allegation or incident immediately to the Director of Nursing (DON) or the Administrator. The RM verbalized the RM was familiar with an allegation the RT of concern was not providing physician ordered care to Resident #17 in October 2024 and the RM had been a part of the investigation into the allegation. The RM was unsure which facility staff member the allegation was initially reported to.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The RM recalled Resident #17's family member reported the RT of concern was not providing care the family member knew was ordered by the physician. Resident #17 had a change in respiratory condition and had to be admitted to the hospital.</p> <p>The RM recalled the RM began a review of Resident #17's clinical record including the Respiratory Administration Record (RAR), physician orders, and the resident's ventilator Alarm and Event Log (log). The RM verbalized the RM discovered Resident #17 had an active ventilator weaning order. The RT documented the RT was completing the ventilator weaning however Resident #17's ventilator log lacked evidence the ventilator settings were changed. The RT of concern was immediately suspended.</p> <p>The RM explained a sprint (weaning) mode was used when taking a resident from a higher level of ventilator support down to allow the resident to perform more work of breathing on their own. The RM verbalized the ventilator machine documented every change made to it in the log, including but not limited to changes in settings and if the ventilator was disconnected. If a resident went from a regular mode to a sprint mode, the change would be documented on the log.</p> <p>The RM explained, if a change was made to the ventilator settings, the log would reflect the words prescription change followed by the settings entered by the RT. The RM reviewed Resident #17's physician order and explained the ventilator log would have read prescription change - pressure support 12, peep to 8.</p> <p>A photo taken by the RM of Resident #17's ventilator log (as displayed on the ventilator monitor) from 10/24/2024 at 7:09 PM, through 10/25/2024 at 8:23 PM, lacked documented evidence of a prescription change as outlined in the physician's order.</p> <p>A Corrective Action Plan dated 10/30/2024, documented the RT of concern was suspended pending further investigation and/or termination of employment. The infraction was described as fraudulent charting practices and professional negligence, documenting care which was not done. Per the facility, to chart the completion of an active physician's order without rendering the care/therapy was an act of negligence and medical fraud. During a monthly chart audit completed on 10/30/2024, the facility found the RT charted completion of active physician order for sprint settings/ventilator weaning parameters to be completed daily. Upon further review by facility staff, of the corresponding ventilator log records, it was found no such changes were made.</p> <p>A Termination Notice dated 11/12/2024, documented the RT was suspended on 10/30/2024, due to allegations of fraudulent charting practices. After completing an investigation, the facility substantiated the allegations and determined the RT violated company policy to treat individuals served with respect and dignity.</p> <p>On 02/20/2025 at 5:32 PM, the Administrator verbalized the Administrator was familiar with an allegation an RT did not provide physician ordered care to Resident #17 in October 2024 and recalled the RM and risk management had investigated the allegation. The Administrator confirmed failure to provide care ordered by the physician was considered neglect.</p> <p>The facility policy titled Participant Rights and Responsibilities, last amended June 2023, documented residents had the right to be free from abuse and neglect.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility policy titled Abuse-Dependent Adult/Child, revised 10/02/2024, documented neglect was the negligent failure of a caregiver to exercise the degree of care a reasonable person in a like position would exercise. Neglect included failure to provide medical care for physical needs and to provide goods and services needed to avoid physical harm, mental anguish, or emotional distress.</p> <p>FRI #NV00072622</p> <p>Cross reference tag F609.</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210</p> <p>Based on interview, record review, and document review, the facility failed to ensure a resident was protected from misappropriation of personal property for 1 of 2 residents sampled for closed records (Resident #25). This deficient practice had the potential to result in resident's limited access to financial resources as well as mental and emotional harm.</p> <p>Findings include:</p> <p>Resident #25</p> <p>Resident #25 was admitted to the facility on [DATE], and discharged on [DATE], with a primary diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>A Facility Reported Incident (FRI) was submitted to the State Agency on 01/07/2025, documenting an allegation of misappropriation of resident property involving the facility Administrator and the previous Recreational Therapist when resident property was commingled with facility petty cash. The FRI documented the alleged incident occurred around 12/20/2025, and the Interim Administrator was notified of the allegations on 01/07/2025.</p> <p>A grievance form filled by the previous Assistant Director of Nursing (ADON) dated 12/26/2024, documented Resident #25 signed out the resident's wallet and noticed 100 dollars in cash was missing from the resident's property. The previous ADON calculated the resident's cash and confirmed the missing money.</p> <p>A witness statement from a Registered Nurse (RN), dated 02/03/2025, documented on 12/04/2024, Resident #25's cash and valuables previously stored in the RN's medication cart were secured in the Administrator's office at the insistence of the Administrator.</p> <p>On 02/20/2025 at 11:27 AM, the Administrator verbalized the Administrator removed resident possessions from the medication carts and placed them in a lock box in the Administrator's office. The Administrator recalled on 12/18/2024, the Recreational Therapist spoke with the Administrator about needing cash to pay vendors at the facility. The Administrator had a petty cash check for 220 dollars and 90 dollars in cash. However, the vendors needed to be paid immediately and there was not time to cash the check. The Administrator verbalized 100 dollars in cash was removed from Resident #25's property kept in the lock box in the Administrator's office and was used to pay the vendors.</p> <p>The Administrator verbalized the Administrator did not intervene when the incident occurred because the Administrator was preparing to go on vacation. The Administrator explained the event would be considered misappropriation because the facility took money from the resident without the resident's consent.</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility policy titled, Funds, Resident Trust Funds, Surety Bonds and Valuables, revised 09/26/2018, documented a current record of all financial arrangements and transactions made to or on behalf of the resident would be maintained by the facility, and the facility would not charge a resident for a service not requested by the resident. Misuse of funds or property belonging to a resident may be considered misappropriation or financial exploitation and would be reported. Examples of misuse included theft of money, commingling of funds, and transfer of resident funds to a facility account.</p> <p>FRI #NV00073128.</p> <p>Complaint #NV00073200.</p> <p>Cross reference with F609.</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on interview, clinical record review, and document review the facility failed to ensure an allegation of neglect for 1 of 12 sampled residents (Resident #17) and an allegation of misappropriation of personal property for 1 of 2 residents sampled for closed records (Resident #25) were reported to the State Agency (SA) within the required timeframe. This deficient practice could result in an untimely investigation of the allegations.</p> <p>Findings include:</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, disorders of diaphragm, dependence on respiratory (ventilator) status, and tracheostomy status.</p> <p>A Facility Reported Incident (FRI) was submitted to the SA on 11/05/2024, documenting an allegation of neglect by a Respiratory Therapist (RT) when the RT did not provide physician ordered care to Resident #17.</p> <p>The FRI documented the alleged incident occurred around 10/27/2024.</p> <p>Documentation of the facility's investigation of the allegation included physician orders, respiratory administration records, a photo of a ventilator log, statements from staff, emails written by the Respiratory Manager (RM), a corrective action plan, and a termination notice.</p> <p>An email sent from the RM to the RM's supervisor (identified by the RM as the Respiratory Regional Director) on 10/30/2024 at 3:27 PM, documented the RM was aware of the following concerns reported by Resident #17's family member:</p> <ul style="list-style-type: none"> -The RT of concern was not providing required care to Resident #17 as ordered by the physician. -The RT demonstrated a lack of concern for multiple residents to which the RT was assigned to care for. -The lack of care by the RT may have contributed to Resident #17's rehospitalization in October 2024. <p>On 02/20/2025 at 5:32 PM, the Administrator, who was also the facility's Abuse Coordinator, verbalized all allegations of abuse and neglect were required to be reported to SA immediately or within 24 hours, depending on the severity. The Administrator confirmed failure of facility staff to provide physician ordered care was considered neglect.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Administrator verbalized the Administrator was familiar with an allegation the RT of concern did not provide physician ordered care to Resident #17. The Administrator explained the concern was initially reported to the facility's Marketer (a sales employee who saw residents in the hospital) on 10/30/2024, and the Administrator was notified of the allegation on 11/05/2024. The Administrator confirmed the Marketer was employed by the facility and the allegation should have been reported to the Administrator and the SA prior to 11/05/2024.</p> <p>The facility policy titled Abuse - Dependent Adult/Child, revised 10/02/2024, documented neglect included failure to provide medical care for physical and mental health needs and failure to provide goods and services needed to avoid physical harm, mental anguish, or emotional distress. Abuse of a resident included neglect and deprivation by a caregiver of goods or services necessary to avoid physical harm or mental suffering. The facility was to report all alleged violations and all substantiated incidents to the SA and to all other agencies as required, in a timely manner. Any person who worked for or had a contractual agreement with the facility was a mandated reporter. Mandatory reporters were not permitted to pass on the reporting obligation to another employee. Staff would immediately (including after hours) report all incidents or suspected incidents of resident abuse, mistreatment, and neglect to the Administrator/DON and the correct reporting agency. When an alleged or suspected case of mistreatment, neglect, or abuse was reported, the Administrator/DON would notify the SA immediately but not later than 24 hours of the alleged incident. Suspected child abuse was required to be reported immediately.</p> <p>FRI #NV00072622</p> <p>50210</p> <p>Resident #25</p> <p>Resident #25 was admitted to the facility on [DATE], and discharged on [DATE], with a primary diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>An FRI was submitted to the SA on 01/07/2025, documenting an allegation of misappropriation of resident property involving the facility Administrator and the Recreational Therapist when resident property was commingled with facility petty cash. The FRI documented the alleged incident occurred around 12/20/2024, and the interim Administrator was notified of the allegations on 01/07/2025.</p> <p>A grievance form filled by the previous Assistant Director of Nursing (ADON) dated 12/26/2024, documented Resident #25 signed out the resident's wallet from the lock box in the Administrator's office, and noticed 100 dollars in cash was missing from the resident's property. The previous ADON calculated the resident's cash and confirmed the missing money.</p> <p>A witness statement from a Registered Nurse (RN), dated 02/03/2025, documented on 12/04/2024, Resident #25's cash and valuables previously stored in the RN's medication cart were secured in the Administrator's office at the insistence of the Administrator.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 02/20/2025 at 11:27 AM, the Administrator verbalized the Administrator removed resident possessions from the medication carts and placed them in a lock box in the Administrator's office. The Administrator recalled on 12/18/2024, the Recreational Therapist spoke with the Administrator about needing cash to pay vendors at the facility. The Administrator had a petty cash check for 220 dollars and 90 dollars in cash. However, the vendors needed to be paid immediately and there was not time to cash the check. The Administrator verbalized 100 dollars in cash was removed from Resident #25's property kept in the lock box in the Administrator's office and was used to pay the vendors.</p> <p>The Administrator verbalized the Administrator did not intervene or report to the SA when the incident occurred because the Administrator was preparing to go on vacation. The Administrator explained the event would be considered misappropriation because the facility took money from the resident without the resident's consent.</p> <p>On 02/20/2025 at 2:05 PM, the Administrator verbalized the Administrator was the facility's Abuse Coordinator and was a mandated reporter. The Administrator explained misappropriation must be reported to the SA within two hours and the investigation completed immediately.</p> <p>The facility policy titled, Funds, Resident Trust Funds, Surety Bonds and Valuables, revised 09/26/2018, documented misuse of funds or property belonging to a resident may be considered misappropriation or financial exploitation and would be reported. Examples of misuse included theft of money, commingling of funds, and transfer of resident funds to a facility account</p> <p>FRI #NV00073128.</p> <p>Complaint #NV00073200.</p> <p>Cross reference with F600 and F602</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on clinical record review, interview and document review, the facility failed to ensure an investigation of a Facility Reported Incident (FRI) related to a resident fall was available for State Agency to review for 1 of 4 residents investigated for FRI (Resident #1). This deficient practice had the potential to affect all residents, resulting in incomplete investigations of potential incidents of abuse and neglect.</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses including spastic diplegic cerebral palsy, diabetes insipidus, and contractures of the right and left knees.</p> <p>Resident #1's Care Plan revised 07/03/2024, documented the resident had a fall with injury on 07/01/2024, and to follow the facility's fall protocol.</p> <p>A Final FRI report submitted by the facility; documented Resident #1 had a fall in the resident's room while receiving care on 07/01/2024. The resident was assessed, and an X-ray was ordered. The FRI report lacked documentation where the fracture was located on the resident or what additional treatment the resident had received.</p> <p>On 02/20/2025 at 10:32 AM, the Regional Support Director of Nursing verbalized having been unable to locate the facility's investigation report for Resident #1's fall in July 2024, and the only investigation information and documentation the facility had were the documents submitted with the FRI to the State Agency.</p> <p>The facility policy titled, Abuse-Dependent Adult/Child, revised 01/06/2016, documented the facility would provide a written report of the results of an investigation and the appropriate action taken to the State Agency or others, as required by law.</p> <p>FRI #NV00071611</p> |

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| <p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observe each nurse aide's job performance and give regular training.</p> <p>46301</p> <p>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 #6). This deficient practice had the potential to affect all residents when the facility did not identify areas of CNA performance in need of inervice education/training.</p> <p>Findings include:</p> <p>Employee #6</p> <p>Employee #6 was hired on 09/20/2023, as a CNA.</p> <p>Employee #6's personnel record lacked documented evidence an annual performance review had been conducted by the employee's anniversary date of 09/20/2024.</p> <p>On 02/20/2025 at 1:30 PM, the Office Manager confirmed Employee #6 did not have an annual performance evaluation for 2024 and Employee #6's annual performance evaluation for 2024 was completed late and the annual performance evaluation had not been completed for 2025. The Office Manager verbalized all CNAs were required to have an evaluation every year by the hire date and they were to be completed by the Director of Nursing.</p> |