STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure 1 of 10 sampled residents (Resident #4) was treated with respect and dignity when the resident's belongings were not inventoried and were removed from the resident's room without notification. This deficient practice had the potential to result in psychosocial harm to the resident and misappropriation of resident property. Findings include:Resident # 4Resident #4 was admitted to the facility on [DATE], with diagnoses including cerebral palsy, developmental disorder of motor function, and dysphagia.Resident #4's inventory list dated 10/13/2023, documented three coats, one shoes, three shirts, two sweaters, three slacks, one pajama, three socks, one bra, one E-Reader/iPad, one backpack, one stuffed plush animal, one bag hair ties, one bag hair accessories, one wheelchair tool kit, one two-piece bathing suit, one iPad stand, wheelchair and two cushions.An email from Resident #4's Guardian to the Social Worker (SW) dated 01/18/2026, documented upon arrival to the facility, the Guardian observed the cupboard in Resident #4's room was completely empty. The cupboard previously contained food items, candy, Tupperware containers, ceramic mugs obtained during vacations, a soup bowl from the resident's great grandmother, approximately $75 in gift cards, and greeting cards from deceased relatives. The Guardian expressed concern the resident's property had been removed from the room without notification and requested assistance in locating the missing items. The Guardian stated many of the items were sentimental and irreplaceable. A grievance form dated 01/20/2026, documented Resident #4's mother sent an email to the SW about missing items from a cabinet in the resident's room. An email from the SW to the Guardian dated 01/21/2026, documented the SW was informed by the Director of Nursing (DON) the missing items were removed from Resident #4's room and placed in a secure cabinet due to an upcoming facility survey. All items would be returned to Resident #4's cupboard except for the gift cards which had not been located. On 03/03/2026 at 3:18 PM, a Certified Nursing Assistant (CNA) explained resident items were documented on an inventory list upon admission and when additional items were brought into the facility. The CNA explained Resident #4's Guardian often visited and brought gifts to the resident. The CNA identified plants, books, stuffed animals, lotions, blankets, clothing, jackets, nightlights and pictures in the resident's room. The CNA verbalized the identified items could have been in the resident's room since admittance. The CNA explained not all items in the resident's room were listed in the resident's inventory sheet and the inventory sheet was quite bare. The CNA verbalized the inventory sheet required updating to accurately reflect the resident's belongings. On 03/03/2026 at 3:45 PM, the SW stated inventory lists were updated upon admission and when new items were brought in. The SW explained it was important to maintain a current and accurate inventory to verify and protect resident belongings. The SW recalled staff relocated Resident #4's items in preparation of a facility survey. When the SW was notified by Resident #4's Guardian the items were missing, the SW talked with the DON and staff present at the time. All items were located and returned to Resident #4 except the gift cards identified by the Guardian. SW explained the gift cards were reportedly Christmas gifts placed in the cupboard by the Guardian. The SW explained the gift cards were not (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented on the resident's personal property inventory list; however, the SW acknowledged the most recent inventory list for Resident # 4 was dated 10/15/2023 and indicated not all of Resident #4's personal belongings were present on the resident's inventory list. The SW verbalized the inventory list required updating. On 03/03/2026 at 4:19 PM, the Administrator stated that the facility ensured resident property was respected by completing an inventory upon admission and updating the list when new items were brought in. Staff were instructed to alert management and update the inventory when new items were observed or reported. The Administrator explained staff may assume belongings of long-term residents were already accounted for, which underscored the need for regular updates. The Administrator confirmed the most recent inventory sheet for Resident #4 was completed in 2023 and verbalized the facility needed to update the inventory to ensure it accurately reflected the resident's belongings. The facility document titled Resident [NAME] of Rights under Federal Law, dated 10/2019, documented residents had the right to retain and use personal clothing and possessions. The facility document titled Personal Effects, revised 01/01/2011, documented upon admission, the admitting nurse or designee would inventory all the resident's personal effects items using the Inventory of Personal Effects form. All items subsequently brought into the facility would be added to the Inventory of Personal Effects form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) for 1 of 10 sampled residents (Resident #6). This deficient practice had the potential to prevent timely investigation of abuse allegations and leave residents vulnerable to abuse.Findings include:Resident #6Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy, mixed receptive-expressive language disorder, cognitive communication deficit, major depressive disorder, recurrent, unspecified, and generalized anxiety disorder.Resident #6's alert progress notes dated 02/10/2026 at 5:37 PM and 5:38 PM, documented Resident #6 was picked up from school due to behaviors. When the resident returned to the facility, the resident was calm and collected. Toileting was performed after school and the resident reported to the floor Certified Nursing Assistant (CNA) the resident was being abused by the teacher and mentioned the teacher by name. The resident started to cry and get vulnerable and emotional with the floor CNA. The floor CNA listened to the resident report the teacher pulled the resident's hair, pinched the resident's arm and yelled at the resident. The resident hated the resident's school and did not like the teacher because of the incident. The floor CNA immediately reported this to the Social Worker with the resident present. The Social Worker (SW) disregarded the resident's report about what happened and the SW said the SW did not believe the teacher would ever do what the resident claimed. The SW said the resident made up a big story and the next time the resident had a behavior, the resident would be expelled from school and denied a virtual visit from the resident's friend as punishment for having had a behavior. The resident and the floor CNA left the SW's office, and the CNA reported the concerns to the Director of Nurses (DON).A nursing progress note dated 02/10/2026 at 7:48 PM, documented Resident #6 had an incident at school. The resident slid out of the resident's wheelchair partially and scraped the resident's back on the pedestal. There was a 9-centimeter (cm) abrasion on the resident's upper back.On 03/02/2026 at 12:21 PM, the CNA verbalized on 02/10/2026 Resident #6 arrived from school with an increase in behaviors to include crying. In the resident's room, Resident #6 informed the CNA the resident's school teacher pulled the resident's hair, pinched the resident's underarms, yelled at the resident, and refused to change the resident when requested. The resident reported the resident was being abused. The CNA assisted the resident to the SW's office and the SW called the teacher on speakerphone. The SW informed the teacher the SW did not believe the teacher would do anything inappropriate to the resident and did not believe what the resident reported. The SW bent to the resident's eye level and informed the resident the SW did not believe what the resident said because the resident fabricated stories. The SW told the resident if the resident did not behave, the resident would not be able to visit with the resident's friend. The CNA verbalized the CNA notified the DON of the report made to the CNA and what was discussed in the SW's office. The CNA explained the Abuse Coordinator was not present at the time. The CNA documented the experience in the resident's electronic health record and later reported the concern to the ombudsman. The CNA explained reports of abuse should be taken seriously. Staff should not take sides or say the residents were wrong to feel a certain way.On 03/02/2026 at 3:57 PM, the SW explained being responsible for the case management of all residents in the facility. The SW verbalized if notified of an abuse allegation, the SW would report to the Abuse Coordinator or DON, and then the allegation would be reported to the SA. Types of abuse included verbal abuse, physical abuse, sexual abuse, and neglect. Signs of abuse included abnormal skin breakdowns, bruising, being spoken to inappropriately, or being left in a soiled brief for a long period of time. The SW recounted approximately one month prior, Resident #6's teacher notified the SW via telephone the resident hit and kicked at the teacher. When asked, the resident responded the teacher hit the resident first. The SW believed the resident had no physical marks. The SW explained believing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was not an accurate historian. The SW explained because the claim did not happen to the SW, the SW could not validate the allegation. The SW would consider getting hit abuse, however the SW did not believe Resident #6's allegation of abuse could have possibly happened. The SW explained there should be documentation of the conversation with the SW and the resident.A behavior progress note dated 03/03/2026, effective 02/10/2026, documented Resident #6 notified the SW the teacher hit the resident first. The resident was unable to elaborate where the resident was hit and the SW found the statement to be confabulatory based on the resident's history of not being an accurate historian.On 03/03/2026 at 11:58 AM, the SW explained Resident #6's teacher was on the phone when the resident and the CNA entered the SW office. The call was on speakerphone and could be heard by all present in the room. The teacher notified the SW the resident hit the teacher and pulled the teacher's hair. The SW asked the resident what happened and the resident responded the teacher hit the resident first. The teacher heard the allegation and informed the SW the SW needed to be careful because the resident fabricated stories. The teacher explained if the resident's behavior did not improve, the resident would be expelled from school. The SW verbalized feeling sorry for the teacher because the SW did not believe the teacher would hit the resident. The SW explained the resident often liked to visit with friends. The SW recalled telling the resident if the resident behaved well, the resident may be able to call the resident's friend. The SW confirmed it was the resident's right to visit their friend regardless of how the resident behaved. The SW reviewed the resident's progress notes and confirmed the note indicating there was a 9 cm abrasion on the resident's back. The SW explained believing the resident fell off the toilet, however confirmed the note indicated the resident returned from the school with an injury.On 03/03/2026 at 12:19 PM, the DON indicated the DON was not sure what the process was for abuse investigating and reporting. The DON identified the Abuse Coordinator, however was unsure who the designee would be. The DON defined neglect as not providing essential services to a resident. Physical abuse was defined as causing physical harm such as punching a resident. It was important to advocate for the residents. The DON explained on the day of the incident, the DON believed Resident #6 was collected from the school due to increased behaviors. The resident talked with two CNAs and the SW. A CNA notified the DON when the resident arrived at the facility, the resident was crying and the resident's briefs were soiled. The DON explained being unsure what happened at the school as the DON was not present in the classroom. The DON did not believe any injuries were identified. The CNA reported to the DON the resident claimed disliking the teacher because the teacher was mean to the resident. The DON immediately notified the Abuse Coordinator; however, the DON did not report the concern.On 03/03/2026 at 1:25 PM, the Abuse Coordinator/Administrator defined abuse as the willful infliction of harm and included hitting, kicking, punching, and slapping. Neglect was defined as the failure to provide a service to a resident. The Abuse Coordinator verbalized the facility would be responsible for reporting an allegation of abuse whether the abuse occurred inside or outside the facility. The Abuse Coordinator would report any allegation of abuse, neglect, exploitation or misappropriation to law enforcement, the ombudsman, the SA, the physician and all responsible parties. The Abuse Coordinator verbalized being notified of Resident #6's increase in behaviors on 02/10/2026. The resident's teacher informed the Abuse Coordinator the resident kicked at the teacher. The Abuse Coordinator did not speak with anyone else regarding the allegation and was unaware of any allegation of abuse by Resident #6. On 03/02/2026, the SW informed the Abuse Coordinator during the interview with the resident on 02/10/2026, the resident told the SW the teacher hit the resident first. When asked where the resident was hit, the resident was unable to specify; thus, the SW determined the resident's statement was unreliable. The Abuse Coordinator confirmed no reports to law enforcement, the ombudsman, the SA, the physician or responsible parties had been made after being notified of the alleged abuse approximately 24 hours earlier.The facility policy titled, Abuse-Dependent Adult/Child, revised 01/06/2016, defined neglect as the failure to assist in personal hygiene, provide medical care, protect from hazards, and prevent malnutrition. Abuse was defined as physical abuse, neglect (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	financial abuse, abandonment, isolation, or deprivation of goods or services necessary to avoid physical harm or mental suffering. When an alleged or suspected case of neglect, injuries of unknown source or abuse was reported the Administrator or DON would notify the SA, the ombudsman, child protective services, and law enforcement. The report would include the name of the resident the type of abuse allegedly committed, the date and time of the incident, the name of all persons involved and the immediate action taken by the facility. The Administrator or DON would immediately notify the Regional Director of Operations, the attending physician, and the resident's representative regarding the alleged incident.Cross reference with tag F610.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure an allegation of abuse was investigated for 1 of 10 sampled residents (Resident #6). This deficient practice had the potential to leave residents vulnerable to abuse.Findings include:Resident #6Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy, mixed receptive-expressive language disorder, cognitive communication deficit, major depressive disorder, recurrent, unspecified, and generalized anxiety disorder.Resident #6's alert progress notes dated 02/10/2026 at 5:37 PM and 5:38 PM, documented Resident #6 was picked up from school due to behaviors. When the resident returned to the facility, the resident was calm and collected. Toileting was performed after school and the resident reported to the floor Certified Nursing Assistant (CNA) the resident was being abused by the teacher and mentioned the teacher by name. The resident started to cry and get vulnerable and emotional with the floor CNA. The floor CNA listened to the resident report the teacher pulled the resident's hair, pinched the resident's arm and yelled at the resident. The resident hated the resident's school and did not like the teacher because of the incident. The floor CNA immediately reported this to the Social Worker with the resident present. The Social Worker (SW) disregarded the resident's report about what happened and the SW said the SW did not believe the teacher would ever do what the resident claimed. The SW said the resident made up a big story and the next time the resident had a behavior, the resident would be expelled from school and denied a virtual visit from the resident's friend as punishment for having had a behavior. The resident and the floor CNA left the SW's office and the CNA reported the concerns to the Director of Nurses (DON). The CNA verbalized the CNA did not speak with the Abuse Coordinator regarding the alleged abuse.A nursing progress note dated 02/10/2026 at 7:48 PM, documented Resident #6 had an incident at school. The resident slid out of the resident's wheelchair partially and scraped the resident's back on the pedestal. There was a 9-centimeter (cm) abrasion on the resident's upper back.On 03/02/2026 at 12:21 PM, the CNA verbalized on 02/10/2026 Resident #6 arrived from school with an increase in behaviors to include crying. In the resident's room, Resident #6 informed the CNA the resident's school teacher pulled the resident's hair, pinched the resident's underarms, yelled at the resident, and refused to change the resident when requested. The resident reported the resident was being abused. The CNA assisted the resident to the SW's office and the SW called the teacher on speakerphone. The SW informed the teacher the SW did not believe the teacher would do anything inappropriate to the resident and did not believe what the resident reported. The SW bent to the resident's eye level and informed the resident the SW did not believe what the resident said because the resident fabricated stories. The SW told the resident if the resident did not behave, the resident would not be able to visit with the resident's friend. The CNA verbalized the CNA notified the DON immediately of the report made to the CNA and what was discussed in the SW's office. The CNA explained the Abuse Coordinator was not present at the time. The CNA documented the experience in the resident's electronic health record and later reported the concern to the ombudsman. The CNA explained reports of abuse should be taken seriously. Staff should not take sides or say the residents were wrong to feel a certain way.On 03/02/2026 at 3:57 PM, the SW explained being responsible for the case management of all residents in the facility. The SW verbalized if notified of an abuse allegation, the SW would report to the Abuse Coordinator or DON, and then the allegation would be reported to the SA. Types of abuse included verbal abuse, physical abuse, sexual abuse, and neglect. Signs of abuse included abnormal skin breakdowns, bruising, being spoken to inappropriately, or being left in a soiled brief for a long period of time. The SW recounted approximately one month prior, Resident #6's teacher notified the SW via telephone the resident hit and kicked at the teacher. When asked, the resident responded the teacher hit the resident first. The SW believed the resident had no physical marks. The SW explained believing the resident was not an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate historian. The SW explained because the claim did not happen to the SW, the SW could not validate the allegation. The SW would consider getting hit abuse, however the SW did not believe Resident #6's allegation of abuse could have possibly happened. The SW explained there should be documentation of the conversation with the SW and the resident.A behavior progress note dated 03/03/2026, effective 02/10/2026, documented Resident #6 notified the SW the teacher hit the resident first. The resident was unable to elaborate where the resident was hit, and the SW found the statement to be confabulatory based on the resident's history of not being an accurate historian.On 03/03/2026 at 11:58 AM, the SW explained Resident #6's teacher was on the phone when the resident and the CNA entered the SW office. The call was on speakerphone and could be heard by all present in the room. The teacher notified the SW the resident hit the teacher and pulled the teacher's hair. The SW asked the resident what happened and the resident responded the teacher hit the resident first. The teacher heard the allegation and informed the SW the SW needed to be careful because the resident fabricated stories. The teacher explained if the resident's behavior did not improve, the resident would be expelled from school. The SW verbalized feeling sorry for the teacher because the SW did not believe the teacher would hit the resident. The SW explained the resident often liked to visit with friends. The SW recalled telling the resident if the resident behaved well, the resident may be able to call the resident's friend. The SW confirmed it was the resident's right to visit their friend regardless of how the resident behaved. The SW reviewed the resident's progress notes and confirmed the note indicating there was a 9 cm abrasion on the resident's back. The SW explained believing the resident fell off the toilet, however confirmed the note indicated the resident returned from the school with an injury.On 03/03/2026 at 12:19 PM, the DON indicated the DON was not sure what the process was for abuse investigating and reporting. The DON identified the Abuse Coordinator, however was unsure who the designee would be. The DON defined neglect as not providing essential services to a resident. Physical abuse was defined as causing physical harm such as punching a resident. It was important to advocate for the residents. On the day of the incident, the DON believed Resident #6 was collected from the school due to increased behaviors. The resident talked with two CNAs and the SW. Then, the CNA came to the DON. The CNA notified the DON when the resident arrived at the facility, the resident was crying and the resident's briefs were soiled. The CNA reported to the DON the resident claimed disliking the teacher because the teacher was mean to the resident. The DON immediately notified the Abuse CoordinatorThe DON explained being unsure what happened at the school as the DON was not present in the classroom. The DON did not believe any injuries were identified. The DON explained when the DON was notified, the DON did not interview the resident, the resident's teacher, or the SW. The DON confirmed the DON did not review Resident #6's electronic health record after becoming aware of the alleged abuse. The DON verbalized the DON was previously unaware of the aforementioned alert notes and nursing progress note documenting the resident returned from school with a newly identified abrasion to the resident's back on the day of the alleged abuse. The DON verbalized a wound assessment should have been completed but was not.On 03/03/2026 at 1:25 PM, the Abuse Coordinator/Administrator explained an abuse investigation consisted of reviewing resident records, reviewing shift assignments, and interviewing residents, family members and staff. The Abuse Coordinator defined abuse as the willful infliction of harm and included hitting, kicking, punching, and slapping. Neglect was defined as the failure to provide a service to a resident. The Abuse Coordinator verbalized the facility would be responsible to report an allegation of abuse whether the abuse occurred inside or outside the facility. The Abuse Coordinator verbalized being notified of Resident #6's increase in behaviors on 02/10/2026. The resident's teacher informed the Abuse Coordinator the resident kicked at the teacher. The Abuse Coordinator did not speak with anyone else regarding the allegation. On 03/02/2026, the SW informed the Abuse Coordinator during the interview with the resident on 02/10/2026, the resident told the SW the teacher hit the resident first. When asked where the resident was hit, the resident was unable to specify; thus, the SW determined the resident's statement was unreliable. The Abuse Coordinator (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbalized the Abuse Coordinator did not collect documented statements from Resident #6, the CNA present on the day of the incident, the SW or the DON, nor did the Abuse Coordinator complete a review of Resident #6's clinical record. The Abuse Coordinator confirmed no investigation into the allegation of abuse had been initiated.The facility policy titled, Abuse-Dependent Adult/Child, revised 01/06/2016, defined neglect as the failure to assist in personal hygiene, provide medical care, protect from hazards, and prevent malnutrition. Abuse was defined as physical abuse, neglect financial abuse, abandonment, isolation, or deprivation of goods or services necessary to avoid physical harm or mental suffering. An investigation would include at a minimum the following, review of the completed incident report form, review of the resident's medical record, interview with the person reporting the incident, interview with any witnesses to the incident, interview with the resident, interview staff who have had contact with the resident, interview the resident's roommate, family members and visitors, and review of all events leading up to the alleged incident.Cross reference with tag F609.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to document the specific resident needs the facility could not meet and attempts to meet the resident's needs when the facility declined to readmit a resident following an acute care hospitalization for 1 of 10 sampled residents (Resident #2). This deficient practice had the potential for residents to be discharged from the facility without a safe discharge plan.Findings include:Resident #2Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia, quadriplegia, C1-C4 complete, and dependence on respirator (ventilator) status.An Admission/Discharge To/From Report documented Resident #2 was discharged from the facility to an acute care hospital on [DATE].A Nursing Shift Summary note dated 06/20/2025 at 2:40 PM, documented Resident #2 was alert and oriented to person, communicated verbally and was able to make basic needs known. The resident required tracheostomy care, ventilator services, gastrostomy tube (g-tube) feeding, received pharmaceutical and non-pharmaceutical interventions for pain, had a pressure injury and a wound vacuum (wound vac). Resident #2 was to be transferred to an acute care hospital for an Incision and Drainage (IND) consult regarding a stage four pressure wound on the resident's right buttock with delayed healing and suspected osteomyelitis.A Social Services Progress Note dated 06/20/2025 at 3:02 PM, documented the Social Worker (SW) notified Resident #2's guardian of the physician's recommendation to transfer Resident #2 to an acute care hospital for surgical evaluation for debridement of a right hip wound and an Infectious Disease (ID) consult for a wound infection. The SW contacted the acute care hospital, the resident was accepted, a bed in the hospital was secured for the resident, and transportation was scheduled for 4:15 PM.Resident #2's clinical record lacked documented evidence the resident returned to the facility and any needs the resident had which the facility could not meet, preventing readmission of the resident.A Discharge Summary from an acute care hospital dated 07/23/2025, documented Resident #2 had several decubiti and had been evaluated by plastic surgery who felt no surgical interventions would benefit the resident. The resident's wounds were stable and required no change to pre-admission management. The resident had received intravenous (IV) pain medication in the hospital; however, the IV pain medication had been stopped in preparation for discharge and the resident's pain was stable to pre-admission status. The resident was being transferred back to the skilled nursing facility in fair and stable condition.On 03/03/2026 in the morning, the Administrator provided documentation including a timeline of Resident #2's stay in the facility, an admission Record, a copy of the resident's signed admission agreement, and several electronic mail (emails) regarding the resident's referral for readmission to the facility. The emails documented the following:-On 07/22/2025 at 12:35 PM, the Ombudsman asked if the hospital had provided any update on a potential readmission of the resident to the facility or any progress on how the resident was doing.-On 07/22/2025 at 1:10 PM, the Administrator explained the facility received updates from the hospital one to two times per week.-On 07/22/2025 at 1:51 PM, the Ombudsman asked if the facility still had a bed available for Resident #2.-On 07/22/2025 at 2:24 PM, the Administrator informed the Ombudsman the facility would hold Resident #2's bed until Friday (07/25/2025) and the resident would need to be clinically stable prior to return to the facility.-On 07/23/2025 at 9:07 AM, a Clinical Marketing Liaison for the facility informed the Administrator, the Director of Nursing (DON) at the time of the referral, and the Ombudsman Resident #2 was medically cleared and ready to return to the facility on [DATE].-On 07/23/2025 at 10:30 AM, the Administrator explained the facility was reviewing the referral and the resident looked different than when the resident was transferred out of the facility. The facility was concerned about the resident's pain medication regimen and an increase in wound sites and condition. There was concern if the resident readmitted to the facility, the resident would likely return to acute (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care promptly.-07/28/2025 at 10:57 AM, a Regional Clinical Marketing Liaison received a call from a case manager at the acute care hospital regarding Resident #2 returning to the facility and indicated the resident was medically ready to return. The resident had been off of IV pain medication since 07/24/2025 and was currently only using a fentanyl patch.-07/28/2025 at 2:26 PM, the Administrator explained the resident's wounds were beyond what the facility could accommodate and there was concern about being able to manage the resident's pain based on what the resident's representative had expressed previously about not wanting the resident on medications (Oxycodone) currently being administered at the hospital.On 03/03/2026 at 12:07 PM, the Administrator verbalized a team including the Administrator, the Administrator's supervisor, the Admissions Coordinator and the DON were typically responsible to review a resident's condition at the time an acute care hospital referred the resident for readmission. The group would determine if a resident was appropriate for readmission and documentation of the meeting/discussion was typically completed via email.The Administrator recalled the facility had concerns about Resident #2's pain medication regimen and wounds when the resident was referred for readmission on [DATE]. The Administrator verbalized the Administrator felt Resident #2's wounds were different than when the resident was initially transferred to the hospital and the hospital had taken the resident off IV pain medication in order to transfer the resident back to the facility. The Administrator confirmed the facility regularly provided pain management and wound care for residents and denied the facility had documentation indicating the transition off of IV pain medication had been ineffective at managing the resident's pain. The Administrator verbalized the Administrator would have to look to see if the facility had any documentation indicating the specific needs of Resident #2 which could not be met by the facility, attempts to meet the needs and if the facility communicated the needs to the hospital.The Administrator denied the facility had a policy regarding permitting a resident to return to the facility following hospitalization.On 03/03/2026 at 2:05 PM, the DON verbalized the DON was one of the facility's Clinical Marketing Liaisons at the time Resident #2 was admitted to an acute care hospital in June 2025 and referred for readmission to the facility in July 2025. The DON recalled the facility declined to readmit Resident #2 to the facility on [DATE] due to worsening of the resident's wounds and recommended the resident be transferred to a Long-Term Acute Care Hospital (LTACH) for wound care and IV pain medication. The DON verbalized the DON was unsure how the resident's wounds were worsening and explained the DON was relaying information from the facility's former wound care nurse to the hospital.The DON acknowledged the acute care hospital discharge summary for Resident #2 documented the resident had been taken off IV pain medication in preparation for transfer back to the facility and the resident's wounds were stable, with no change to pre-admission management. The DON confirmed the facility regularly provided wound care and pain management care to residents and explained the facility's process for admission of residents included residents needing to be off IV pain medication for at least 24 hours prior to admission/readmission.The DON recalled Resident #2 received a dose of IV pain medication in the morning on 07/23/2025. Documentation from the acute care hospital revealed Resident #2 received a dose of IV Fentanyl on 07/23/2025 at 7:51 AM. The DON verbalized the DON was unsure if the facility had any documentation of the resident's needs the facility could not meet, attempts to meet the needs, and communication with the hospital on [DATE] and 07/25/2025, 24 hours after the last dose of IV pain medication and while a bed in the facility remained available for Resident #2. Prior to the end of the survey, the facility failed to provide documentation of Resident #2's needs the facility could not meet and attempts to meet the needs at the time the resident was referred for readmission.The facility's Resident admission Agreement, dated 05/05/2022, section VII - Transfers and Discharges, documented the facility would not transfer or discharge a resident against the resident's wishes unless given written prior notice which reflected the time within which the resident could resume residency in the facility without waiting for readmission upon the first availability of a bed in a semi-private room. Section VIII - Bed Hold Policy, documented after hospitalization, residents had the right to be readmitted to the facility's first available bed if the facility failed to provide written (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notice of the resident's right to a 7-day bed hold and if the facility agreed the resident met admission criteria. If the resident was a Medicaid recipient, the resident had the right to the facility's first available bed following hospitalization even if the resident had been absent from the facility for more than seven days.CPT 2605398Cross reference tag F628

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to provide written notice of the facility's bed-hold policy to a resident and the resident's representative upon transfer to an acute care hospital for 1 of 10 sampled residents (Resident #2). This deficient practice had the potential to result in psychosocial harm to residents due to not being able to return to the resident's previous room. Findings include:Resident #2Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia, quadriplegia, C1-C4 complete, and dependence on respirator (ventilator) status.An Admission/Discharge To/From Report documented Resident #2 was discharged to an acute care hospital on [DATE].A Social Services Progress Note dated 06/20/2025 at 3:02 PM, documented the Social Worker (SW) notified Resident #2's guardian of the physician's recommendation to transfer Resident #2 to an acute care hospital for surgical evaluation for debridement of a right hip wound and an Infectious Disease (ID) consult for a wound infection. The SW contacted the acute care hospital, the resident was accepted, a bed in the hospital was secured for the resident, and transportation was scheduled for 4:15 PM.Resident #2's clinical record lacked documented evidence the resident and the resident's representative were provided written notice of the facility's bed-hold policy upon transfer to an acute care hospital.On 03/03/2026 at 4:15 PM, the Administrator verbalized the Administrator usually called or emailed residents and residents' representatives to provide notification of the facility's bed-hold policy when a resident was transferred to an acute care hospital. If the facility had to call 911 and the resident had to be transferred emergently, the facility's first priority was to ensure the resident was taken care of and the notification may be provided after the resident left the facility.The Administrator confirmed Resident #2 was transferred to an acute care hospital on [DATE] and recalled the Administrator called Resident #2's representative on 07/22/2025 and left a message regarding paying a bed-hold fee. The Administrator denied the facility provided written notice regarding the facility's bed-hold policy to Resident #2 and the resident's representative upon transfer to the hospital and acknowledged documentation in the resident's clinical record indicated the transfer was coordinated and did not require staff to call 911 to transfer the resident emergently.The Administrator denied the facility had policies related to transfers, discharges, and bed-holds and verbalized information related to the topics were included in the facility's admission packet.The facility's Resident admission Agreement, dated 05/05/2022, section VII - Transfers and Discharges, documented the facility would not transfer or discharge a resident against the resident's wishes unless given written prior notice which reflected the time within which the resident could resume residency in the facility without waiting for readmission upon the first availability of a bed in a semi-private room. 30 days advance written notice would be provided for involuntary transfers and discharges unless the reason for the transfer or discharge was to protect the resident's health and safety, then less than 30 days notice could be provided. Section VIII - Bed Hold Policy, documented if a resident left the facility and did not return by midnight the same day, a bed hold charge would be billed unless contractual stipulations prohibited the charge. After hospitalization, residents had the right to be readmitted to the facility's first available bed if the facility failed to provide written notice of the resident's right to a 7-day bed hold and if the facility agreed the resident met admission criteria. If the resident was a Medicaid recipient, the resident had the right to the facility's first available bed following hospitalization even if the resident had been absent from the facility for more than seven days.CPT 2605398Cross reference tag F627

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295103	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on clinical record review, interview and document review, the facility failed to ensure clinical records were complete and accurate for 1 of 10 sampled residents (Resident #7). This deficient practice had the potential to result in duplicate administration of treatments/medications to residents and for residents' response to care provided and refusals of care to not be documented and available for review as necessary.Findings include:Resident #7Resident #7 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia and cystic fibrosis with pulmonary manifestations.Resident #7's February 2026 Respiratory Administration Record (RAR), documented the following:-Check emergency equipment at bedside including manual resuscitator every shift. The start date was 02/02/2026. Scheduled administrations on the RAR lacked documentation of the completion of the task and were left blank on 02/08/2026, 02/17/2026, 02/19/2026, and 02/23/2026.-Continuous pulse oximetry every shift. The start date was 02/02/2026. Scheduled administrations on the RAR lacked documentation of the completion of the task and were left blank on 02/08/2026, 02/17/2026, 02/19/2026, and 02/23/2026.-Oxygen at 60 cubic centimeters (cc)/ minute via Nasal Cannula (NC). Ok to titrate to Room Air (RA) as long as saturations (sats) are greater than 93%, every shift for oxygen saturation. The start date was 12/06/2025. Scheduled administrations on the RAR lacked documentation of the completion of the task/treatment and were left blank on 02/08/2026, 02/17/2026, 02/19/2026, and 02/23/2026.-Rotate pulse oximeter (ox) probe every shift. The start date was 02/02/2026. Scheduled administrations on the RAR lacked documentation of the completion of the task and were left blank on 02/08/2026, 02/17/2026, 02/19/2026, and 02/23/2026.-Albuterol Sulfate inhalation nebulization solution, 3 milliliters (ml) inhale orally via nebulizer every eight hours for shortness of breath. The start date was 01/31/2026. Scheduled administrations on the RAR lacked documentation of the completion of the treatment and were left blank on 02/04/2026, 02/08/2026, and 02/16/2026 - 02/19/2026.-Chest percussion every eight hours for respiratory insufficiency. The start date was 01/31/2026. Scheduled administrations on the RAR lacked documentation of the completion of the task and were left blank on 02/04/2026, 02/08/2026, and 02/16/2026 - 02/19/2026.-HyperSal inhalation nebulization solution 7% (Sodium Chloride), 3 ml inhale orally via nebulizer every eighter hours for secretions. The start date was 12/15/2025. Scheduled administrations on the RAR lacked documentation of the completion of the treatment and were left blank on 02/04/2026, 02/08/2026, and 02/16/2026 - 02/19/2026.On 03/02/2026 at 12:58 PM, the Director of Nursing (DON) verbalized respiratory care and treatments were documented on the RAR. The DON reviewed Resident #7's February 2026 RAR and confirmed the blank spaces noted above. The DON verbalized the DON was not sure if staff had not provided the care/treatment or had failed to document the care/treatment. The DON confirmed if care or a treatment was held or refused the RAR should reflect the care/treatment as held or refused and verbalized the RAR should not have been left blank.The facility policy titled Documentation - Medical Record, revised 11/07/2024, documented staff were to document assessments, interventions, procedures, treatments, outcomes and services provided. If a resident refused medications and/or treatments, staff were to document such refusal in the resident's record.