

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31739</p> <p>Based on clinical record review and interview, the facility failed to provide the Center for Medicare and Medicaid Services (CMS) Form 10055 Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN), and Form 10123, Notice of Medicare Non-Coverage (NOMNC) for 1 of 2 residents discharged from a Medicare covered Part A stay with benefit days remaining within the previous six months (Resident #26). This deficient practice had the potential to negatively impact the resident(s) ability to make informed decisions about their care.</p> <p>Findings include:</p> <p>Resident #26</p> <p>Resident #26 was admitted to the facility on [DATE], with diagnoses including essential primary hypertension and generalized muscle weakness.</p> <p>Resident #26's documented Medicare Part A Skilled Services Episode start date was 12/20/2024. The documented last covered day of Part A services was 02/02/2025.</p> <p>Resident #26's record lacked documented evidence of having received either form CMS-10055 or form CMS-10123.</p> <p>On 02/19/2025 at 12:36 PM, the Regional Support Director of Nursing (DON) confirmed Resident #26 was in the facility from 12/20/2024 to 02/02/2025, and should have received both forms CMS-10055 and CMS-10123, as the resident's stay in the facility was covered by Medicare Part A.</p> <p>The Regional Support DON verbalized the facility could not locate copies of the forms provided to the resident, and the forms may not have been completed due to the facility not having had a social worker or case worker.</p> <p>The Regional Support DON verbalized the facility should have provided the forms to the resident and maintained the forms in the resident's record.</p> <p>On 02/21/2025 at 9:55 AM, the Regional Support DON verbalized having been unable to locate a policy on beneficiary notifications.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31739</p> <p>Based on observation, clinical record review, interview, and document review, the facility failed to ensure a comfortable, homelike environment when a resident had reported the exit door for employees in the 200 Hall had been closing loudly resulting in disruption in the resident's sleep for 1 of 11 residents in the 200 Hall (Resident #2). This deficient practice had the potential to affect the resident's sleep patterns by exposing the resident to unnecessary noise disturbances, potentially leading to a less comfortable living environment.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on [DATE], with diagnoses including circadian rhythm sleep disorder, free running type, and sleep disorder, unspecified.</p> <p>On 02/19/2025 at 10:49 AM, Resident #2 verbalized having submitted a grievance in December 2024, about the exit door in the 200 Hall closing loudly when staff would exit the facility waking up the resident several times a night. The resident verbalized the facility had yet to address the resident's grievance.</p> <p>On 02/20/2025 at 3:30 PM, Resident #2 verbalized the resident was awakened every night due to the staff exiting the facility through the door just left of the resident's room. The resident explained how difficult it had been to sleep through the night with the door slamming closed and the resident having sleep disorders.</p> <p>On 02/20/2025 at 3:38 PM, the Director of Nursing confirmed staff used the door next to Resident #2's room as an exit.</p> <p>On 02/20/2025 at 3:43 PM, the Administrator opened the exit door in the 200 Hall and allowed the door to close on its own. The Administrator confirmed the door closed hard and was loud enough to wake up residents in the hall. The Administrator verbalized it was the first time having been made aware the exit door in the 200 Hall was a noise concern with a resident.</p> <p>The facility policy titled, Resident Rooms, Capacity, Furnishings, Storage, Space, Conversion, Privacy, revised 09/12/2019, lacked documented language of environmental considerations for residents related to noise levels.</p> <p>On 02/20/2025 at 4:28 PM, the Administrator verbalized the policy on resident rooms was the only policy the facility had related to a homelike environment.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>31739</p> <p>Based on interview and document review, the facility failed to ensure resident grievances were documented, investigated and a determination and/or resolution was provided to the resident(s). This deficient practice had the potential to result in a resident having an unresolved grievance.</p> <p>Findings include:</p> <p>The Resident Council Meeting Minutes dated 01/06/2025, documented the residents' concern of the facility not having responded to written submitted grievances.</p> <p>During the Resident Council Meeting with the surveyors on the morning of 02/19/2025, one resident verbalized the facility had yet to respond to a written grievance the resident submitted in December 2024.</p> <p>On 02/20/2025 at 4:47 PM, the Administrator verbalized the facility did not have documented complaints or grievances from residents as the binder where the grievance forms were kept could not be located. The Administrator verbalized the binder had been missing since the Licensed Social Worker left employment with the facility several weeks previous, and the facility had not made attempts to re-create or gather the missing information.</p> <p>The facility policy titled, Grievance Policy, revised 06/22/2015, documented the facility shall conduct an investigation of the complaint and a decision will be issued in written form to the resident no later than thirty (30) days after submission. Grievance forms shall be retained for a period of one (1) year.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50210</p> <p>Based on interview and clinical record review, the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 1 of 12 sampled residents (Resident #19). This deficient practice had the potential to deprive the resident of a person-centered care plan and the associated interventions and services relative to their current health management needs.</p> <p>Findings include:</p> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], with a primary diagnosis of hemiplegia, unspecified affecting left nondominant side.</p> <p>An Admission MDS assessment dated [DATE], Section K - Swallowing/Nutritional Status, documented Resident #19 had a weight loss of 5 percent (%) or more in the last month or a loss of 10% or more in the last six months without being on a physician prescribed weight-loss regimen.</p> <p>A weights and vitals summary dated 02/20/2025, documented the following weights taken prior to or on the 01/02/2025 date of the MDS assessment:</p> <p>-152.7 pounds on 12/26/2024.</p> <p>On 02/19/2025 at 5:33 PM, the MDS RN verbalized different sections of the MDS were completed by different people including the MDS RN and the Dietician and explained the Dietician completed Section K of the MDS assessment. The MDS RN confirmed Resident #19's MDS assessment documented Resident #19 had a weight loss of 5% or more in the last month or a loss of 10% or more in the last six months without being on a physician prescribed weight-loss regimen. The MDS RN reviewed Resident #19's weights and vitals summary and confirmed the resident did not have any weight loss by the time the MDS assessment was completed.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46301</p> <p>Based on personnel record review, document review, and interview, the facility failed to ensure direct care staff maintained current Cardio-Pulmonary Resuscitation (CPR) certification for 2 of 12 sampled direct care employees (Employee #14 and #16). This deficient practice could result in a negative outcome for a resident requiring CPR while awaiting the arrival of emergency medical personnel.</p> <p>Findings include:</p> <p>Employee #14</p> <p>Employee #14 was hired as a Licensed Practical Nurse (LPN) with a start date of [DATE].</p> <p>The LPN's personnel record documented CPR training and certification expired on ,d+[DATE].</p> <p>Employee #16</p> <p>Employee #16 was hired as a Certified Nursing Assistant (CNA) with a start date of [DATE].</p> <p>The CNA's personnel record documented CPR training and certification expired on ,d+[DATE].</p> <p>On [DATE] at 12:58 PM, the Office Manager verbalized CPR certification was required to be taken by all direct care staff and confirmed Employees #14 and #16 did not have a current CPR certification.</p> <p>The Facility Assessment, completed on [DATE], documented all staff would be Basic Life Support certified.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50210</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure an as needed (PRN) psychotherapeutic medication was prescribed to a resident with a diagnosed indication for use, was limited to 14 days, was monitored for side effects, and had behavior monitoring for 1 of 12 sampled residents (Resident #19). This deficient practice had the potential to result in an unmanaged medication regimen, missed signs of worsening condition, and compromised resident safety.</p> <p>Findings include:</p> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], with a primary diagnosis of hemiplegia, unspecified affecting left nondominant side.</p> <p>An active physician's order dated 01/08/2025, documented Hydroxyzine Hydrochloride (HCl) oral tablet, give 25 milligrams (mg) via gastrostomy (g) tube every 24 hours PRN for episodes of feeling anxious or stressed over recent life changes.</p> <p>Resident #19's electronic health record (EHR) lacked documentation of an anxiety diagnosis.</p> <p>Resident #19's physician orders lacked evidence of side effect monitoring or behavior monitoring for Hydroxyzine HCl.</p> <p>Resident #19's January and February 2025 Medication Administration Records (MARs) dated 02/19/2025, documented Hydroxyzine HCl was administered to the resident from 01/09/2025 through 02/15/2025.</p> <p>Resident #19's Minimum Data Set 3.0 (MDS) assessment dated [DATE], Section I - Active Diagnoses, lacked documentation of an anxiety diagnosis.</p> <p>On 02/19/2025 at 4:03 PM, a Registered Nurse (RN) verbalized Resident #19's EHR included an active physician's order dated 01/08/2025, for Hydroxyzine HCl PRN for anxiety; however, the EHR lacked evidence of an anxiety diagnosis. The RN confirmed the Hydroxyzine HCl was administered from 01/09/2025 through 02/15/2025. Additionally, the RN confirmed Resident #19's record lacked behavior monitoring and side effect monitoring related to the Hydroxyzine HCl order.</p> <p>On 02/19/2025 at 4:59 PM, the Regional Support Director of Nursing (RSDON) verbalized as-needed psychotherapeutic medications could be administered for 14 days, required behavior and side effect monitoring and should relate to a diagnosis from the resident's record.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The RSDON confirmed Resident #19's EHR included an active physician's order dated 01/08/2025, for Hydroxyzine HCl administered PRN for anxiety, but did not document a diagnosis of anxiety. The RSDON confirmed the Hydroxyzine HCl was administered through 02/15/2025, exceeding the 14-day limit for as-needed psychotherapeutic medications. Additionally, Resident #19's record lacked behavior monitoring and side effect monitoring related to the Hydroxyzine HCl order.</p> <p>The facility policy titled Restraints-Psychotherapeutic Medications, revised 07/13/2021, documented psychotherapeutic medications included antianxiety medications. A PRN psychotherapeutic medication would be entered for only 14 days and behavior monitoring for psychotherapeutic medications would be documented every shift.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49557</p> <p>Based on observation, interview, and document review the facility failed to remove expired medications from the active supply in 2 of 2 medication storage rooms and 2 of 3 medication carts reviewed for medication storage. This deficient practice had the potential for expired medications to be administered to residents.</p> <p>Findings include:</p> <p>On 02/19/2025 at 3:10 PM, in the presence of a Licensed Practical Nurse (LPN), the medication cart in the 400 unit was inspected. A bottle of Diphenhydramine Hydrochloride (HCl), oral solution 12.5 milligrams (mg)/ 5 milliliters (ml) was found in the cart, stored with active medications. The expiration date printed on the bottle was January 2025.</p> <p>The LPN confirmed the bottle of Diphenhydramine HCl had expired at the end of January 2025.</p> <p>On 02/19/2025 at 3:22 PM, in the presence of the LPN, the medication storage room on the 400 unit was inspected. The following items were found in the cabinets in the medication storage room:</p> <ul style="list-style-type: none"> <li>-Three bottles of Iron supplement liquid 220 mg/ 5 ml. The expiration date printed on the bottles was December 2024.</li> <li>-One bottle of Geri-Tussin 100 mg/ 5 ml. The expiration date printed on the bottle was October 2024.</li> </ul> <p>The LPN confirmed the three bottles of Iron supplement liquid and bottle of Geri-Tussin had expired. The LPN verbalized expired medication should have been removed from storage with active medications and placed in the bin in the medication storage room designated for drug destruction/disposal.</p> <p>On 02/19/2025 at 3:35 PM, in the presence of a Registered Nurse (RN) 1, a medication cart on the 300 unit was inspected. A bubble pack containing 12 tablets of Ondansetron 4 mg tablets was found in the cart, stored with active medications. The expiration date on the bubble pack was January 2025.</p> <p>The RN1 confirmed the Ondansetron tablets had expired at the end of January 2025. The RN1 explained the process for handling of expired medications included removing the medication from the medication cart and placing it in a bin in the medication storage room designated for drug destruction/disposal.</p> <p>On 02/20/2025 at 9:04 AM, in the presence of RN2, the medication storage room on the 200 unit was inspected. The following items were found in the cabinets in the medication storage room:</p> <ul style="list-style-type: none"> <li>-One box of Bisacodyl 10 mg suppositories with 36 suppositories remaining in the box. The expiration date printed on the box was January 2025.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-One box of Bisacodyl 10 mg suppositories with 100 suppositories remaining in the box. The expiration date printed on the box was January 2025.</p> <p>The RN2 confirmed the boxes of Bisacodyl suppositories had expired. The RN2 verbalized the expired medication should have been removed from storage with active medications and placed in the bin in the medication storage room designated for drug destruction/disposal.</p> <p>On 02/20/2025 at 10:04 AM, the Director of Nursing (DON) verbalized expired medications were to be destroyed. The DON verbalized expired medications should be removed from medication carts and cabinets in the medication storage room. If expired medications were not removed from storage with active medications, the expired medications could be administered to residents by mistake.</p> <p>The facility policy titled, Storage and Expiration Dating of Medications and Biologicals, revised 08/01/2024, documented the facility was to ensure medications and biologicals with an expired date on the label were stored separate from other medications until destroyed or returned to the pharmacy/supplier. Medications with a manufacturer's expiration date expressed in month and year would expire on the last day of the month.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49557</p> <p>Based on clinical record review, interview, and document review the facility failed to ensure physical therapy (PT) frequency of treatment was provided per the physician's order for 1 of 12 sampled residents (Resident #3). This deficient practice had the potential to prevent residents from attaining or maintaining the residents' highest practicable level of strength, balance, and endurance.</p> <p>Findings include:</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic quadriplegic cerebral palsy, muscle weakness (generalized), and abnormal posture.</p> <p>A Physician's Order dated 01/08/2025, documented PT quarterly reassessment completed. Recommend skilled PT one hour per week for 12 weeks to improve strength, endurance, balance, and overall functional activity tolerance.</p> <p>Resident #3's Care Plan documented Resident #3 had limited physical mobility and was a high fall risk related to diagnoses of spastic quadriplegic cerebral palsy and muscle weakness. The date initiated was 10/08/2019 and the revision date was 01/29/2024. Interventions included:</p> <p>-Weight bearing as tolerated. PT and Occupational Therapy (OT) will work on standing in standing frame. Required to wear bilateral ankle foot orthoses (AFOs) when standing to protect against skin breakdown and protect joints. The date initiated was 10/08/2019, and the revision date was 01/29/2024.</p> <p>-Encourage Resident #3 to participate in activities promoting exercise and physical activity for strengthening and improved mobility. The date initiated was 10/08/2019, and the revision date was 01/29/2024.</p> <p>On 02/21/2025 at 8:19 AM, the Regional Support Director of Nursing (RSDON) provided documentation of all PT provided to Resident #3 from 01/01/2025 through 02/21/2025.</p> <p>A PT Progress Note dated 01/08/2025, documented PT quarterly assessment completed, recommending continued PT one hour per week for 12 weeks. Will grow out resident's wheelchair next week.</p> <p>Progress Notes from Resident #3's clinical record documented Resident #3 received PT on the following dates: 01/16/2025, 01/21/2025, 01/30/2025, and 02/19/2025.</p> <p>The Progress Notes provided by the RSDON and Resident #3's clinical record lacked documented evidence Resident #3 received PT from 02/02/2025 through 02/15/2025, a two-week period.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Caremeridian Llc, Dba Neurorestorative		STREET ADDRESS, CITY, STATE, ZIP CODE  3980 Lake Placid Drive Ste 2 Reno, NV 89511	
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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/21/2025 at 8:30 AM, the RSDON verbalized there was no other documentation of PT provided to Resident #3 during the month of February 2025. The RSDON explained the RSDON had spoken to the facility's Director of Rehabilitation and confirmed Resident #3 did not receive PT from 02/02/2025 through 02/15/2025. The RSDON verbalized the facility's rehabilitation department had been short staffed. The RSDON reviewed the Physician's Order dated 01/08/2025, and acknowledged the order indicated Resident #3 was to receive one hour of PT per week.</p> <p>The facility policy titled, Standard MD Orders, last amended January 2013, documented nursing or designee would provide health care when needed as regulated by the physician. Physical Therapy would evaluate and institute appropriate treatment for each resident.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>49557</p> <p>Based on interview and document review, the Administrator failed to ensure the Facility Assessment (FA) included all portions of the facility's resident population and any ethnic, cultural or religious factors with the potential to affect the care provided by the facility. This deficient practice had the potential to deprive residents of necessary care and services to meet each resident's individual needs and preferences.</p> <p>Findings include:</p> <p>The FA, approved by the Administrator on 01/16/2025, documented the facility provided a continuum of post-acute care and rehabilitation to children. The facility accepted infants to young adults. The section of the FA titled resident population, type of unit, and census documented the facility was designed to provide children with a safe, home-like environment, while receiving specialized, skilled care. The facility had created an atmosphere favorable to young patients' recovery including distinctly decorated rooms and rehabilitation equipment specifically designed for children.</p> <p>The FA lacked documentation related to the facility's adult resident population, the unit where adult residents were cared for and any ethnic, cultural, or religious factors which could affect the care provided by the facility.</p> <p>On 02/19/2025 at 12:42 PM, the Administrator verbalized the Administrator was responsible to complete the FA once per year. Completing the FA included reviewing the needs and complexity of the residents in the facility, staffing and training needs. The Administrator confirmed all resident types and all care required by the residents in the facility should have been included in the FA. The Administrator confirmed the FA should have addressed any ethnic, cultural, or religious factors with potential to affect the care provided by the facility.</p> <p>The Administrator reviewed the FA and confirmed the FA did not include the facility's adult resident population and did not address any ethnic, cultural, or religious factors with the potential to affect care provided by the facility.</p> <p>On 02/19/2025 at 5:08 PM, the Administrator verbalized the facility did not have a policy related to the completion or required components of the FA. The Administrator verbalized the facility followed state and federal regulations.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49557</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure 1) residents with psychotherapeutic medications had a documented pre-restraining assessment per facility policy for 5 of 5 residents sampled for unnecessary medications (Residents #9, #17, #2, #13, and #19) and 2) a consent had been obtained for a psychotherapeutic medication per the facility's policy for 1 of 5 residents sampled for unnecessary medications (Resident #9). This deficient practice had the potential to result in the accidental use of psychotherapeutic medications as chemical restraints and residents receiving psychotherapeutic medications prior to being informed of the risks and benefits of the medication.</p> <p>Findings include:</p> <p>Pre-restraining assessment</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on [DATE], with diagnoses including spastic hemiplegic cerebral palsy, unspecified, emotional and behavioral disorder, unspecified, and generalized anxiety, unspecified.</p> <p>A physician's order dated 11/07/2024, documented Sertraline Hydrochloride (HCl) oral tablet, give 150 milligrams (mg), via gastrostomy tube, one time a day for anxiety.</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including tracheostomy status and encounter for attention to tracheostomy.</p> <p>A physician's order dated 12/21/2024, documented Fluoxetine HCl solution 20 mg/ 5 milliliters (ml). Give 3.75 ml by mouth one time a day for depression.</p> <p>A physician's order dated 12/10/2024, documented Lorazepam oral tablet 1 mg. Give 1 mg by mouth as needed for anxiety with trach changes. Give 30-60 minutes prior to trach changes.</p> <p>50210</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, single episode, mild.</p> <p>A physician's order dated 11/26/2024, documented Cymbalta oral capsule delayed release particles 60 mg. Give 60 mg by mouth one time a day for depression and chronic pain starting on 12/23/2024.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #13</p> <p>Resident #13 was admitted to the facility on [DATE], with diagnoses of anxiety disorder, unspecified and depression, unspecified.</p> <p>A physician's order dated 05/20/2024, documented Hydroxyzine HCl oral tablet 25 mg. Give one tablet by mouth three times a day for anxiety.</p> <p>A physician's order dated 06/13/2024, documented Escitalopram Oxalate tablet 20 mg. Give one tablet by mouth one time a day for depression.</p> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], with a primary diagnosis of hemiplegia, unspecified affecting the left nondominant side.</p> <p>A physician's order dated 05/20/2024, documented Hydroxyzine HCl oral tablet, give 25 mg via gastrostomy tube every 24 hours as needed for episodes of feeling anxious or stressed over recent life changes.</p> <p>On 02/19/2025 at 4:03 PM, a Registered Nurse (RN) confirmed Resident #2 had an order for Cymbalta, Resident #13 had orders for Hydroxyzine HCl and Escitalopram Oxalate, and Resident #19 had an order for Hydroxyzine HCl.</p> <p>The electronic health records (EHRs) of Residents #9, #17, #2, #13, and #19 lacked documentation of a pre-restraining assessment related to their ordered psychotherapeutic medications.</p> <p>On 02/19/2025 at 4:59 PM, the Regional Support Director of Nursing (RSDON) verbalized psychotherapeutic medications included anti-anxiety medications, antidepressants, and antipsychotics. The RSDON confirmed the facility policy required all residents with a psychotherapeutic medication to have a pre-restraining assessment. The RSDON explained the facility had not done pre-restraining assessments for any residents in the facility related to psychotherapeutic medications.</p> <p>The facility policy titled Restraints-Psychotherapeutic Medications, revised 07/13/2021, documented psychotherapeutic medications included antipsychotic, antidepressant, hypnotic, and antianxiety/sedative medications. The policy also documented a pre-restraining assessment would be performed prior to obtaining a physician's order for psychotherapeutic medications.</p> <p>31739</p> <p>Consent</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on [DATE], with diagnoses including spastic hemiplegic cerebral palsy, unspecified, emotional and behavioral disorder, unspecified, and generalized anxiety, unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's order dated 11/07/2024, documented Sertraline HCl oral tablet, give 150 mg, via gastrostomy tube, one time a day for anxiety.</p> <p>Resident #9's Medication Administration Records for Sertraline HCl oral tablet, 150 mg, one time a day for anxiety, was documented as administered per the physician's order from 11/07/2024 through the start date of the survey.</p> <p>The facility policy titled, Restraints-Psychotherapeutic Medications, revised 07/13/2021, documented a psychotherapeutic medication would not be ordered or administered if a consent had not been obtained prior to administration and the consent had not been reviewed by the physician.</p> <p>Resident #9's clinical record lacked documented evidence a consent had been obtained prior to the administration of sertraline.</p> <p>On 02/19/2025 at 4:22 PM, the Regional Support Director of Nursing confirmed the facility had not obtained a consent for Resident #9 prior to the resident having been administered Sertraline and should have obtained a consent per the facility's policy.</p> <p>The facility policy titled, Medical Records Maintenance-Facility and Off-Site, revised 09/26/2018, documented the facility would maintain each resident's medical record in a complete, accurate, organized fashion, and readily accessible to those persons authorized to review the record. Information in the record was not to be lost, destroyed, or used in an unauthorized manner.</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>50210</p> <p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to ensure corrective action was implemented to address identified problems related to the lack of Enhanced Barrier Precautions (EBP) for residents with a chronic wound or indwelling medical device. This deficient practice had the potential to result in the exposure of all residents, staff and visitors to harmful infectious agents.</p> <p>Findings include:</p> <p>On 02/21/2025 at 10:28 AM, during the QAPI review with the Administrator, the Administrator verbalized the facility had not identified a concern related to the lack of EBP for residents with a chronic wound or indwelling medical device until the middle of January 2025. The Administrator confirmed when the facility was made aware, no EBP was implemented and no current residents of the facility had EBP.</p> <p>The job description for facility Administrator dated 11/29/2011, documented the Administrator was responsible for the Performance Improvement Program.</p> <p>Cross reference with F880.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</b></p> <p>Based on observation, interview, clinical record review, and document review the facility failed to ensure 1) Enhanced Barrier Precautions (EBP) were implemented for 20 of 20 residents with an indwelling medical device (Resident #2, #14, #8, #23, #17, #10, #15, #6, #9, #228, #5, #7, #1, #20, #4, #176, #19, #3, #227, and #12) according to the facility's policy, training provided at a staff meeting, and Centers for Disease Control (CDC) guidance, 2) an increase in respiratory infections in the pediatric unit was investigated and control measures were implemented for 4 of 9 residents with infections in December 2024 (Resident #7, #17, #15, and #3) and 3) quarterly legionella testing was completed according to the facility's water management program. These deficient practices had to the potential for transmission of infectious diseases among all residents and staff in the facility without adequate identification, surveillance, and implementation of control measures.</p> <p>Findings include:</p> <p>Enhanced Barrier Precautions</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on [DATE], with diagnoses including neuromuscular dysfunction of bladder, unspecified and personal history of urinary tract infections.</p> <p>Resident #2's Order Summary Report documented the following active physician orders:</p> <p>-Change Foley (indwelling urinary catheter) every 30 days. Catheter size 20 French (FR), balloon size 30 milliliters (ml). The order date was 04/21/2024.</p> <p>-Indwelling catheter care every shift and as needed (PRN) for neurogenic bladder. The order date was 10/11/2023.</p> <p>Resident #14</p> <p>Resident #14 was admitted to the facility on [DATE], with diagnoses including dysphagia, oropharyngeal phase, encounter for attention to tracheostomy, and encounter for attention to gastrostomy.</p> <p>Resident #14's Medication Review Report documented the following active physician orders:</p> <p>-Enteral feed order, every shift Jevity 1.5 continuous at 60 ml/ hour (hr). The order date was 12/22/2024.</p> <p>-Change Foley every 30 days. Catheter size 14 FR, balloon size five ml. The order date was 11/02/2024.</p> <p>-Change tracheostomy (trach) every 30 days and PRN. The order date was 10/03/2024.</p> <p>Resident #8</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including autonomic dysreflexia, encounter for attention to gastrostomy, and neuromuscular dysfunction of bladder, unspecified.</p> <p>Resident #8's Medication Review Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, PediaSure with fiber 1,188 ml run at 66 ml/ hr for 18 hours. Off at 8:00 AM. Flush with 200 ml water before and after feed. The order date was 10/20/2023.</li> <li>-Cleanse Mic-key button (a low-profile feeding tube) site with normal saline solution, pat dry, leave open to air, every night shift. The order date was 09/19/2023.</li> <li>-Change Supra-Pubic catheter 16 FR with five ml balloon every month and PRN. The order date was 09/18/2023.</li> </ul> <p>Resident #23</p> <p>Resident #23 was admitted to the facility on [DATE], with a diagnosis of osteomyelitis, unspecified and gastrostomy status.</p> <p>Resident #23's Medication Review Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, at bedtime mix one pouch of Compleat Pediatric puree (300 ml) with 260 ml water and run at 70 ml/ hr for eight hours. The order date was 02/06/2025.</li> <li>-Enteral feed order, three times a day mix one pouch of Compleat Pediatric puree (300 ml) with 100 ml of water, run at 400 ml/ hr. The order date was 02/06/2025.</li> <li>-Gastrostomy tube (G-tube) stoma care: cleanse with normal saline (NS) every shift and ensure Hydrofera blue dressing is in place. Change Hydrofera blue dressing every day and as needed for soiling. The order date was 02/19/2025.</li> </ul> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including tracheostomy status and encounter for attention to tracheostomy.</p> <p>Resident #17's Order Summary Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Change trach every seven days on Tuesday. Two-person trach change always. Clean trach every shift. The order date was 10/07/2024.</li> <li>-Respiratory Therapist (RT), Registered Nurse (RN), or Licensed Practical Nurse (LPN) to do trach care every shift and PRN. The order date was 10/02/2024.</li> </ul> <p>Resident #10</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-G-tube site care every shift with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 09/13/2023.</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy and gastrostomy status.</p> <p>Resident #9's Medication Review Report documented the following active physician orders:</p> <p>-Enteral feed order, one time a day for hydration maintenance flush via gravity with 650 ml of Pedialyte. May bolus or run on pump. The order date was 12/31/2024.</p> <p>-Enteral feed order, one time a day for hydration maintenance flush via gravity with 650 ml of water. The order date was 12/31/2024.</p> <p>-G-tube site care every shift with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 08/03/2022.</p> <p>Resident #228</p> <p>Resident #228 was admitted to the facility on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter and tracheostomy status.</p> <p>Resident #228's Order Summary Report documented the following active physician orders:</p> <p>-Change trach every 30 days and PRN. The order date was 02/10/2025.</p> <p>-RT, RN, or LPN to do trach care every shift and PRN. The order date was 02/03/2025.</p> <p>Resident #5</p> <p>Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic quadriplegic cerebral palsy and encounter for attention to gastrostomy.</p> <p>Resident #5's Medication Review Report documented the following active physician orders:</p> <p>-Enteral feed order, bolus one can PediaSure with fiber PRN if resident eats less than 75 percent of meal for two consecutive meals. The order date was 11/02/2020.</p> <p>-Change G-tube every three months on the fifth day of the month. 18 FR, 2.7 cm. The order date was 10/14/2024.</p> <p>-G-tube care every shift and PRN. Clean with normal saline. The order date was 12/09/2020.</p> <p>Resident #7</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Caremeridian Llc, Dba Neurorestorative		STREET ADDRESS, CITY, STATE, ZIP CODE 3980 Lake Placid Drive Ste 2 Reno, NV 89511	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy, tracheostomy status, and gastrostomy status.</p> <p>Resident #7's Medication Review Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, four times a day, 237 ml of PediaSure 1.0 with fiber with 85 ml flush before and after. Add one scoop of Beneprotein at 6:00 AM and 6:00 PM. Run at 287 ml/ hr at 6:00 AM, 12:00 PM, 6:00 PM and 10:00 PM. The order date was 06/19/2024.</li> <li>-G-tube site care every shift with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 01/09/2023.</li> <li>-Trach care every shift. The order date was 08/19/2024.</li> </ul> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic diplegic cerebral palsy and gastrostomy status.</p> <p>Resident #1's Medication Review Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, one time a day. Jevity 1.2, 500 ml mixed with 250 ml of water at 100 ml/ hr at 9:00 PM. The order date was 10/31/2023.</li> <li>-Enteral feed order, three times a day. Jevity 1.2, 250 ml mixed with 250 ml of water at 400 ml/ hr. The order date was 10/31/2023.</li> <li>-Percutaneous Endoscopic Gastrostomy (PEG) tube site care, every shift, with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 02/27/2024.</li> </ul> <p>Resident #20</p> <p>Resident #20 was admitted to the facility on [DATE], with diagnoses including unspecified intracranial injury with loss of consciousness status unknown, subsequent encounter and encounter for attention to gastrostomy.</p> <p>Resident #20's Order Summary Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, two times a day, Jevity 1.2 at 65 ml/ hr continuously via PEG tube. 150 ml water flush every four hours. The order date was 12/02/2024.</li> <li>-G-tube site care every shift with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 10/29/2024.</li> </ul> <p>Resident #4</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including thyrotoxicosis, unspecified without thyrotoxic crisis or storm and encounter for attention to gastrostomy.</p> <p>Resident #4's Medication Review Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, with meals by mouth (PO) and G-tube, daily goal of 1500 ml. Target of 240 ml per meal, bolus remainder of what not taken following meal. The order date was 12/20/2022.</li> <li>-G-tube site care every shift with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 12/20/222.</li> </ul> <p>Resident #176</p> <p>Resident #176 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia.</p> <p>Resident #176's Medication Review Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, five times a day, Jevity 1.5 via gravity bag. Flush with 75 cubic centimeters (cc) of water before and after feeds. The order date was 02/19/2025.</li> <li>-G-tube site care every shift with warm soap and water. May apply gauze dressing PRN for drainage. The order date was 09/17/2024.</li> <li>-Change trach base every 30 days and PRN. The order date was 02/12/2025.</li> <li>-Trach care every shift. The order date was 02/11/2025.</li> </ul> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], with diagnoses including hemiplegia, unspecified affecting left nondominant side and dysphagia, oropharyngeal phase.</p> <p>Resident #19's Order Summary Report documented the following active physician orders:</p> <ul style="list-style-type: none"> <li>-Enteral feed order, every shift, Osmolite 1.2 to run continuously at 80 ml/ hr. Ok to use Osmolite 1.5 at 70 ml/ hr if Osmolite 1.2 not available. The order date was 01/12/2025.</li> <li>-Feeding tube care (size 20 FR) every shift and PRN. The order date was 12/27/2024.</li> </ul> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dependence on respirator (ventilator) status, encounter for attention to tracheostomy, and encounter for attention to gastrostomy.</p> <p>Resident #3's Medication Review Report documented the following active physician orders:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Enteral feed order four times a day for nutrition. Mix Neocate [NAME] to 24 kilocalories (kcal): seven scoops of Neocate [NAME] with nine ounces of water, then add one scoop of Beneprotein mixed with two ounces of water and run at 100 ml/ hour (hr). The order date was 08/11/2024.</p> <p>-Cleanse Mic-Key button site with normal saline solution, pat dry, leave open to air every shift. The order date was 09/19/2023.</p> <p>-Change trach, Portex 7.0 every month, every day shift every four weeks on Tuesday for routine trach care. Change trach after resident's shower. The order date was 06/17/2024.</p> <p>-Trach care every shift and PRN. The order date was 10/21/2019.</p> <p>Resident #227</p> <p>Resident #227 was admitted to the facility on [DATE], with diagnoses including nontraumatic subarachnoid hemorrhage from unspecified carotid siphon and bifurcation, tracheostomy status, and gastrostomy status.</p> <p>Resident #227's Order Summary Report documented the following active physician orders:</p> <p>-Enteral tube feeding diet, Glucerna 1.2 (or Jevity 1.2) at 70 ml/ hr via G-tube continuously. The order date was 02/06/2025.</p> <p>-Change trach every 30 days and PRN. The order date was 02/10/2025.</p> <p>-Trach care every shift. The order date was 02/09/2025.</p> <p>Resident #12</p> <p>Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other specified congenital deformities of hip and encounter for attention to gastrostomy.</p> <p>Resident #12's Medication Review Report documented the following active physician orders:</p> <p>-Enteral feed order, at bedtime, PediaSure 1.5 to run for eight hours at 100 ml/ hr, on at 9:00 PM, off at 5:00 AM. The order date was 12/08/2024.</p> <p>-Enteral feed order, G-tube care every shift. The order date was 11/08/2024.</p> <p>On 02/18/2025 at 8:24 AM, during a tour of the facility, no signage for EBP and no personal protective equipment (PPE) carts were noted on residents' doors or near residents' rooms in the 200, 300, and 400 units.</p> <p>On 02/19/2025 at 9:20 AM, a Registered Nurse (RN) 1 administered medications to Resident #20 through the resident's gastrostomy tube. The RN was not wearing a gown.</p> <p>On 02/19/2025 at 2:29 PM, two staff members transferred Resident #10 from a wheelchair to the resident's bed. Neither staff member was wearing a gown.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 02/20/2025 at 3:03 PM, an RN2 administered medication to Resident #1 through the resident's gastrostomy tube. The RN2 was not wearing a gown.</p> <p>On 02/18/2025 at 10:58 AM, the Director of Nursing (DON) verbalized EBP would be implemented for residents with droplet or respiratory precautions. If EBP was implemented for a resident, the precautions would be indicated by a sign on the resident's door. The DON denied the facility had any residents on transmission-based precautions or EBP.</p> <p>On 02/19/2025 at 2:45 PM, the RN1 verbalized the RN1 had received training upon hire related to infection control. The training included different types of isolation precautions, how to dispose of hazardous waste, and hand hygiene. The RN1 denied the training included EBP. The RN1 verbalized the RN1 was not aware of what EBP was and denied EBP was currently in use in the facility.</p> <p>On 02/20/2025 at 12:01 PM, during an interview with the DON and the Regional Support DON (RSDON) who was also the facility's Infection Preventionist (IP), the RSDON/IP verbalized the intent of EBP was to prevent organisms from transferring onto staff members' clothing and being spread to residents. Residents eligible for EBP included those with tracheostomies, G-tubes, Foley catheters or any other invasive medical device and those colonized with a Multidrug-resistant Organism (MDRO). The RSDON/IP confirmed Resident #2, #14, #8, #23, #17, #10, #15, #6, #9, #228, #5, #7, #1, #20, #4, #176, #19, #3, #227, and #12 had indwelling medical devices.</p> <p>The RSDON/IP verbalized the facility was still working on how to implement EBP in the facility to ensure the facility was following state and CDC recommendations however, the facility had not yet implemented EBP for any residents.</p> <p>The August 2024 Monthly Cornerstone (staff meeting) included education related to EBP. A Centers for Medicare and Medicaid Services Quality, Safety, and Oversight Group memorandum titled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, was attached to the meeting and documented the CDC had introduced EBP as a strategy to decrease transmission of MDROs. EBP recommendations included use of EBP (gown and glove use) for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of MDRO status. MDRO transmission was common in long-term care facilities and contributed to substantial resident morbidity and mortality.</p> <p>A Job Description for the position of Infection Preventionist, dated 12/01/2024, documented the IP was responsible for the effective direction, management, and operation of the infection prevention program. The IP utilized evidence-based practices such as those published by the CDC. The IP ensured sources of infection were isolated to limit the spread of infectious organisms. The IP was to plan, implement, evaluate and disseminate appropriate public health practices.</p> <p>The facility policy titled Infection Control Program Overview, dated 04/10/2007 and reviewed 01/13/2025, documented the goals of the infection control program included decreasing the risk of infection to residents and personnel. The program addressed detection, prevention, and control of infections. Prevention of spread of infections was accomplished by use of standard precautions and other barriers.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility policy titled Enhanced Barrier Precautions for Skilled Nursing Facilities (SNFs), effective January 2023, documented EBP was an infection control intervention designed to reduce transmission of resistant organisms and employed targeted gown and glove use during high contact care activities. EBP applied to residents with wounds and indwelling medical devices or who had been infected/colonized with an MDRO. Examples of indwelling medical devices included urinary catheters, feeding tubes, and tracheostomies/ventilators. Examples of high contact resident care activities included dressing, bathing, transferring, device care or use, and wound care. EBP was intended to be in place for the duration of a resident's stay or until discontinuation of the indwelling medical device placing them at a higher risk.</p> <p>Respiratory infections in the pediatric unit</p> <p>Resident #7</p> <p>Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy and tracheostomy status.</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including tracheostomy status, and encounter for attention to tracheostomy.</p> <p>Resident #15</p> <p>Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic quadriplegic cerebral palsy and encounter for attention to gastrostomy.</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dependence on respirator (ventilator) status and encounter for attention to tracheostomy.</p> <p>The facility's Monthly Line Listing of Resident Infections for November 2024, documented Resident #7 had a respiratory infection. The onset date was documented as 11/10/2024. The column titled Isolated (isolation precautions) was blank.</p> <p>The facility's Monthly Line Listing of Resident Infections for December 2024, documented Residents #7, #17, #15, and #3 had respiratory infections. The column titled Isolated was blank for Resident #7 and was marked No for Residents #17, #15, and #3.</p> <p>Residents #7, #17, #15, and #3 were in the facility's pediatric unit.</p> <p>On 02/20/2025 at 12:01 PM, during an interview with the DON and the RSDON/IP, the RSDON/IP explained the facility identified, tracked and monitored infections in the facility with a monthly line listing. If an increase in infections was noted, the facility would investigate to assure residents were receiving appropriate care. For example, if the facility noted an increase in ventilator-associated pneumonia the facility would investigate to assure residents were getting up to a chair everyday and were getting oral hygiene as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The RSDON/IP reviewed the Monthly Line Listing of Resident Infections for November and December 2024 and acknowledge an increase from one respiratory infection in November to four respiratory infections in December in the pediatric unit. The RSDON/IP verbalized the RSDON/IP did not have a reason or explanation for the increase in respiratory infections and denied any investigation was completed related to the increase as it was cold and flu season at the time.</p> <p>The RSDON/IP verbalized Resident #7 would have been placed on contact precautions due to the resident's sputum culture testing positive for methicillin-resistant staphylococcus aureus (MRSA) and denied any enhanced or transmission-based precautions would have been implemented for Residents #17, #15, and #3 due to the lack of a positive sputum culture. Staff knew when residents were sick staff could wear a mask, and masks were available to staff, but staff were not required to wear any PPE outside of standard precautions. The RSDON/IP verbalized the RSDON/IP had no idea if any training or in-service had been provided to staff at the time of the increase in respiratory infections.</p> <p>The facility policy titled Infection Control Program Overview, dated 04/10/2007 and reviewed 01/13/2025, documented the goals of the infection control program included decreasing the risk of infection to residents and personnel, monitoring for occurrence of infection, implementing appropriate control measures, and identifying and correcting problems relating to infection control practices.</p> <p>Water testing</p> <p>On 02/20/2025 at 10:25 AM, during a review of the facility's Water Management Program, monitoring of control measures implemented in the facility to prevent growth and spread of legionella and other waterborne pathogens included visual inspections for debris and biofilm, checking residual chlorine/disinfectant levels, checking water temperatures at various locations in the facility, and quarterly legionella testing.</p> <p>Included with the Water Management Program was a results report dated 12/30/2024. The results report documented the facility's water was tested at six locations within the building. All locations had ideal amounts of free and total chlorine. No bacteria strains were identified. No other test results were kept with the program.</p> <p>On 02/20/2025 at 10:46 AM, the Maintenance Manager explained the facility ensured all sources of water in the facility were ran/used at least once a week and service was completed on bathtubs weekly to help prevent legionella and other waterborne pathogens in the facility's water system. The Maintenance Manager verbalized the facility utilized an outside agency to conduct quarterly testing for legionella and was unsure why the results for the remaining three quarters of 2024 were not kept with the Water Management Program.</p> <p>On 02/20/2025 at 2:05 PM, the Maintenance Manager provided a copy of a results report for water testing completed in the facility on 03/13/2024. The Maintenance Manager explained the facility was only performing water testing two times per year and not quarterly as outlined in the Water Management Program.</p> <p>The facility's Water Management Program, initiated 09/02/2020, documented the water management program team included the Administrator, the Director of Nursing, and the Maintenance Manager. Monitoring of the facility's control measures included quarterly legionella testing. Test results would be kept with the water management program.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>49557</p> <p>Based on interview, and document review the facility failed to ensure education regarding the facility's Antimicrobial Stewardship Program (ASP)/antibiotic use was provided to staff and facility staff documented an evaluation to determine if residents met or did not meet McGeer criteria, according to the facility's program/policy, prior to initiation of antibiotic therapy. This deficient practice had the potential to affect all residents in the facility and placed residents at risk of developing antibiotic-resistant infections.</p> <p>Staff training</p> <p>On 02/19/2025 at 2:45 PM, a Registered Nurse (RN) verbalized the RN had worked for the facility for approximately one year. The RN denied the RN had received any training related to the facility's antimicrobial/antibiotic stewardship program. The RN verbalized the facility did not have an antibiotic stewardship program, did not perform antibiotic timeouts, and all decisions related to prescribing of antibiotics were made by the physician.</p> <p>On 02/20/2025 at 12:01 PM, the Regional Support Director of Nursing (RSDON)/Infection Preventionist (IP) verbalized the RSDON/IP could not confirm staff had received any formal training on the facility's Antimicrobial Stewardship Program or the reasons for the program.</p> <p>The facility's Antimicrobial Stewardship Program, dated 04/10/2007 and reviewed 01/13/2025, documented the facility was to provide continuing education to all facility staff in all departments regarding antimicrobial stewardship such as antimicrobial resistance, facility efforts to minimize resistance to antimicrobials and appropriate assessment of residents suspected of having an infection.</p> <p>Documentation of suspected infections</p> <p>On 02/19/2025 at 2:45 PM, an RN explained if the RN suspected a resident had an infection, the RN would check vital signs, assess the resident for any changes from the resident's baseline condition and report to the physician. The RN denied the facility had a specific form for staff to complete or criteria required to be documented for suspected infections, prior to initiation of antibiotic therapy.</p> <p>The Monthly Line Listing of Resident Infections for November 2024 documented an antibiotic was prescribed for 9 of 11 total infections in the facility. The line listing did not include an assessment protocol and did not indicate if the resident met or did not meet criteria for antibiotic therapy.</p> <p>The Monthly Line Listing of Resident Infections for December 2024 documented an antibiotic was prescribed for 9 of 9 total infections in the facility. The line listing did not include an assessment protocol and did not indicate if the resident met or did not meet criteria for antibiotic therapy.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/20/2025 at 12:01 PM, the RSDON/IP explained the facility tracked communicable diseases and antibiotic use in the facility with a monthly line listing and a daily review of new antibiotic prescriptions started the previous day. The RSDON/IP verbalized the facility used McGeer criteria to identify infections. The RSDON/IP explained the RSDON/IP had an electronic version of McGeer's criteria which could be reviewed with the physician over the phone however, the assessment tool/criteria was not documented in residents' records. The RSDON/IP verbalized the RSDON/IP was unsure if a system was in place to assure all required assessments and parts of an antibiotic order were documented, according to the facility's policy, prior to the initiation of antibiotic therapy. The RSDON/IP reviewed the Monthly Line Listing of Resident Infections for November and December 2024 and confirmed the line listing did not indicate if the residents' status met minimum criteria for initiating antibiotics.</p> <p>The facility's Antimicrobial Stewardship Program, dated 04/10/2007 and reviewed 01/13/2025, documented it was the policy of the facility to implement an antimicrobial stewardship program to promote appropriate use of antibiotics while optimizing the treatment of infections and reducing possible adverse events associated with antibiotic use. The core elements of stewardship included leadership, accountability, action to implement recommended policies or practices, tracking measures, and education for staff about antibiotic resistance. If staff suspected a resident had an infection, the nurse was to perform and document a complete assessment of the resident using established and accepted assessment protocols to determine if the resident's status met minimum criteria for initiating antibiotics. The facility used McGeer criteria to determine if minimum criteria for initiating antibiotics had been met.</p> <p>Assessment of the facility's antimicrobial stewardship program could include reviewing for completeness of assessment and documentation of the assessment at the time the antimicrobial was ordered, laboratory findings, rationale for use of the antimicrobial, completeness of antimicrobial orders, and assuring antimicrobial selection was consistent with recommended agents for specific indications.</p>		

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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>46301</p> <p>Based on personnel record review, interview and document review, the facility failed to ensure initial and annual elder abuse prevention training was completed timely for 6 of 18 sampled employees (Employees #2, #3, #6, #7, #10, and #11). This deficient practice had the potential to place all residents at risk for abuse and neglect.</p> <p>Findings include:</p> <p>Employee #2</p> <p>Employee #2 was hired as the Director of Nursing (DON) on 12/20/2024.</p> <p>Employee #2's personnel record lacked documented evidence elder abuse prevention training was completed upon hire.</p> <p>Employee #3</p> <p>Employee #3 was hired as the Registered Dietician on 10/18/2018.</p> <p>Employee #3's personnel record documented elder abuse prevention training completed 10/06/2022, however lacked documented evidence elder abuse training was completed in 2024.</p> <p>Employee #6</p> <p>Employee #6 was hired as a Certified Nursing Assistant (CNA) on 09/20/2023.</p> <p>Employee #6's personnel record documented elder abuse prevention training completed 09/26/2023, however lacked documented evidence elder abuse training was completed in 2024.</p> <p>Employee #7</p> <p>Employee #7 was hired as a Certified Nursing Assistant (CNA) on 02/17/2023.</p> <p>Employee #7's personnel record documented elder abuse prevention training completed 09/29/2023, however lacked documented evidence elder abuse training was completed in 2024.</p> <p>Employee #10</p> <p>Employee #10 was hired as a Registered Nurse on 01/30/2022.</p> <p>Employee #10's personnel record lacked annual elder abuse prevention training completed.</p> <p>Employee #11</p> <p>(continued on next page)</p>		

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	

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employee #11 was hired as a Licensed Practical Nurse on 01/05/2022.</p> <p>Employee #11's personnel record lacked initial and annual elder abuse prevention training completed.</p> <p>On 02/20/2025 at 1:02 PM, the Office Manager verbalized abuse training was to be completed within the first orientation, and annually thereafter. Staff were not permitted to work on the floor prior to the completion of abuse training. All staff were required to complete abuse training. The Office Manger confirmed Employees #2, #3, #6, #7, #10, and #11 lacked timely elder abuse training.</p> <p>The facility policy titled, Abuse - Dependent Adult/Child, revised 10/02/2024, documented initial abuse training must be completed prior to the employee starting floor training. All healthcare workers during orientation, annually and as needed receive education and training on abuse.</p>

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	
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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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>46301</p> <p>Based on interview and document review, the facility failed to provide twelve hours of in-service training as a result of performance evaluations for 2 of 2 sampled Certified Nursing Assistants (CNA) who have been with the facility for more than one year. This deficient practice had the potential to place all residents at risk of receiving care from staff without the required knowledge and competency to perform their duties.</p> <p>Findings include:</p> <p>Employee #6</p> <p>Employee #6 was hired on 09/20/2023, as a CNA. The employee'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>Employee #7</p> <p>Employee #7 was hired on 02/17/2023, as a CNA. The employee's personnel record documented an annual performance review had been conducted on 07/11/2024, 145 days after the employee's anniversary date of 02/17/2024. Employee #7's personnel record lacked documented evidence an annual performance review had been conducted by the employees anniversary date of 02/17/2025.</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 the employee lacked the required 12-hour in-service training. Employee #7's annual performance evaluation for 2024 was completed late. Employee #7's annual performance evaluation had not been completed for 2025 and the employee lacked the required 12-hour in-service training. 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>		