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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	3980 Lake Placid Drive Ste 2 Reno, NV 89511

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure 1) a resident and/or the resident representative, and the Ombudsman were notified of the reason for transfer in writing when a resident was transferred to an acute care hospital for inpatient care for 1 of 2 residents reviewed for closed records (Resident #30) and 3 of 3 sampled residents reviewed for hospitalizations (Resident #26, #2, #5) and 2) a resident and/or the residents representative were provided notification of the facility's bed hold policy upon transfer to an acute care hospital for 1 of 3 sampled residents reviewed for hospitalizations (Resident #5). This deficient practice had the potential to result in a resident or the resident's representative not being aware of the facility's bed hold policy when the resident required hospitalization, and the resident/resident representative and the Ombudsman not being aware of the reason for transfer, the date of transfer and the resident's rights related to transfers. Findings include: Resident #30 Resident #30 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with a primary diagnosis of acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia. A Minimum Data Set 3.0 (MDS) , Section A, dated 07/22/2025, documented Resident #30 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 03/12/2026, documented Resident #30 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. Resident #30's clinical record did not include documentation a written notice of transfer, including the reason for transfer, was completed and provided to the resident, the resident's representative, and/or the Ombudsman when the resident was transferred and admitted to an acute care hospital on [DATE] and 03/10/2026. Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], and 03/24/2026 with diagnoses including non-ST elevation myocardial infarction (NSTEMI), Guillain-Barre Syndrome, and anxiety disorder, unspecified. AN MDS assessment, Section A, dated 03/02/2026, documented Resident #26 had an unplanned discharge, with return anticipated, to an acute care hospital. (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An MDS assessment, Section A, dated 03/20/2026, documented Resident #26 had an unplanned discharge, with return anticipated, to an acute care hospital. Resident #26's clinical record did not include documentation a written notice of transfer, including the reason for transfer, was completed and provided to the resident, the resident's representative, and/or the Ombudsman when the resident was transferred and admitted to an acute care hospital on [DATE] and 03/19/2026. Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses including acute respiratory failure, unspecified whether with hypoxia or hypercapnia, quadriplegia, C1-C4 complete, and dependence on respirator [ventilator] status, tracheostomy status, and gastrostomy status. An MDS assessment, Section A, dated 03/10/2026, documented Resident #2 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 03/18/2026, documented Resident #2 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 04/09/2026, documented Resident #2 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 04/22/2026, documented Resident #2 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. Resident #2's clinical record did not include documentation a written notice of transfer, including the reason for transfer, was completed and provided to the resident, the resident's representative, and/or the Ombudsman when the resident was transferred and admitted to an acute care hospital on [DATE], 03/18/2026, 04/09/2026, and 04/22/2026. Resident #5 Resident #5 was admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, anoxic brain damage, not elsewhere classified, tracheostomy status, gastrostomy status, and cerebral infarction, unspecified. An MDS assessment, section A, dated 10/10/2025, documented Resident #5 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 10/31/2025, documented Resident #5 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 12/01/2025, documented Resident #5 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. An MDS assessment, Section A, dated 01/26/2026, documented Resident #5 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An MDS assessment, Section A, dated 03/10/2026, documented Resident #5 had an unplanned discharge, with return anticipated, to an acute care hospital on [DATE]. Resident #5's clinical record did not include documentation a written notice of transfer, including the reason for transfer, was completed and provided to the resident, the resident's representative, and/or the Ombudsman when the resident was transferred and admitted to an acute care hospital on [DATE], 10/31/2025, 12/01/2025, 01/26/2026, and 03/10/2026. Resident #5's clinical record did not include documentation the resident and/or the resident representative were provided notification of the facility's bed hold policy when the resident was transferred and admitted to an acute care hospital on [DATE]. On 05/07/2026 at 11:40 AM, the Administrator verbalized the Social Worker was not aware a written notice of transfer was supposed to be sent to the Ombudsman. The Administrator confirmed a written notice of transfer had not been completed and/or sent to the Ombudsman for any resident transferred and admitted to an acute care hospital between 03/10/2025 and 05/07/2026, including Residents #26, #30, #2 and # 5. The Administrator confirmed a bed hold notification and not been completed and sent to Resident #5's representative for the resident's hospital admission on [DATE]. The facility policy titled Discharge or Transfer of a Resident revised 11/06/2024, documented the facility must notify the Office of the State of Long-Term Ombudsman anytime the facility initiated a transfer or discharge, and the transfer or discharge was necessary to meet the resident's welfare and the resident's welfare could not be met at the facility. Notifications were made to the resident, family, and/or authorized representative. The policy did not indicate or instruct what the resident, family, and/or Ombudsman were to be notified of when a resident was transferred or discharged to an acute care facility, including a written reason for transfer and notification of the bed hold policy.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to ensure 1) the infection prevention program included a process to ensure staff were screened for eligibility to receive a Covid-19 (COVID) vaccine, education was provided regarding the COVID vaccine to be administered, consent was obtained, the vaccine was administered or declined, and documentation of the vaccination or declination was retained, and 2) an Infection Preventionist (IP) worked at the facility from 09/17/2025 through 03/31/2026. Findings include:Staff COVID VaccinationsOn 05/05/2026 at 10:41 AM, the Regional Director of Nursing (Regional DON) provided the Infection Control Manual to the survey team, which did not include staff COVID infection monitoring, staff immunizations, or resident care related to COVID. The Regional DON explained the facility was not required to track the staff immunizations since the National Healthcare Safety Network (NHSN) did not require staff COVID immunization reporting.On 05/05/2026 at 3:58 PM, the Administrator explained the facility did not require staff to obtain COVID vaccinations. The Administrator verbalized not knowing staff COVID vaccinations were still required to be offered and confirmed the facility did not document the offering, education, or consent for the staff COVID vaccine. The Administrator confirmed the Regional DON worked remotely and there was not an IP on site from 09/17/2025 through 03/31/2026. On 05/06/2026 at 1:09 PM, the Regional DON explained staff were offered the COVID vaccination with staff vaccine clinics but did not retain or track staff COVID vaccinations, offerings, education, or consented administration or declination of the vaccine. On 05/06/2026 at 1:31 PM, the Director of Nursing/Infection Preventionist (DON/IP) confirmed the facility used Centers for Disease Control and Prevention (CDC) vaccination guidelines. The IP explained staff COVID vaccination status was required upon hire, went into the employee file, and was not tracked or monitored by the IP. On 05/07/2026 at 3:54 PM, the Administrator explained the QAPI committee discussed immunizations at the last QAPI meeting, however COVID vaccinations were not addressed. The Administrator confirmed the QAPI committee did not identify a concern related to the infection prevention program and did not establish a process to ensure staff were screened for eligibility to receive a COVID vaccine, education was provided regarding the COVID vaccine to be administered, consent was obtained if the vaccine was administered or declined, and documentation of vaccination or declination was retained for all staff.A CDC document titled Staying Up to Date with COVID-19 Vaccines, last updated on 11/19/2025, document the CDC recommended the 2025-2026 updated COVID vaccines to protect against serious illness from COVID. Everyone aged six months and older should get one dose of an updated COVID vaccine. The 2025-2026 COVID vaccines were updated to give the best protection from currently circulating strains.The facility policy titled Infection Control Program Overview, reviewed 01/13/2026, documented immunizations were offered as appropriate to personnel to decrease the incidence of preventable infectious diseases. The IP was responsible to carry out the functions of the Infection Control Program.Infection Preventionist On 05/05/2026 at 1:34 PM, the Regional DON confirmed the Regional DON was the previous facility IP and became the remote IP for the facility on 09/17/2025. The Regional DON confirmed the Regional DON worked remotely from another location and visited the facility once per month until the current IP became certified on 04/01/2026. The facility job description titled Infection Preventionist, dated 06/24/2019, documented the IP was responsible for the effective management and operation of the infection prevention program, including the education of facility staff members. The IP utilized evidence-based practices such as those published by the CDC. The IP conducted educational activities for healthcare workers through instructions and dissemination of information on healthcare practices.Cross referenced with tags F835, F 882, and F887

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review the facility failed to ensure 1) an Infection Preventionist (IP) with the required specialized training worked at the facility from 09/17/2025 through 03/31/2026, and 2) the IP had a process in place to ensure staff were offered COVID-19 vaccines. This deficient practice had the potential to increase the risk of infection transmission within the facility.Findings include:Infection Preventionist On 05/05/2026 at 1:34 PM, the Regional Director of Nursing (Regional DON) explained the Regional DON was the previous facility IP and became the remote IP for the facility on 09/17/2025, when the Regional DON took a position at another location. The Regional DON confirmed working remotely as the facility IP from 09/17/2025 through 3/31/2026. The Regional DON visited the facility once per month until the current IP became certified on 04/01/2026.The facility job description titled Infection Preventionist, dated 06/24/2019, documented the IP was responsible for the effective management and operation of the infection prevention program, including the education of facility staff members. The IP utilized evidence-based practices such as those published by the Centers for Disease Control and Prevention (CDC). The IP conducted educational activities for healthcare workers through instructions and dissemination of information on healthcare practices.Staff VaccinationOn 05/05/2026 at 3:58 PM, the Administrator confirmed the facility did not require staff to get COVID vaccinations. Staff were handed an informational flyer regarding a sign up for a facility vaccination clinic provided by a local pharmacy. The Administrator explained the education, offering, and monitoring of the staff COVID vaccinations was not documented and did not know it was required.On 05/06/2026 at 1:09 PM, the Regional DON explained COVID vaccinations were offered to staff with other vaccination offerings when the facility provided a staff vaccination clinic and were not documented or tracked as it was staff's personal choice to get the vaccination. The Regional DON verbalized all staff were required to provide proof of COVID vaccination upon hire but did not track the vaccinations beyond the hire date. The Regional DON explained the facility should have tracked and documented staff vaccinations and was unsure of when staff was last offered the COVID vaccination.On 05/06/2026 at 1:31 PM, the IP confirmed the IP did not have documentation staff were screened for eligibility to receive a COVID vaccination and/or a booster vaccine, education regarding the vaccine was provided, and if the vaccine was offered and either administered or declined. The IP verbalized the facility followed CDC infection control and vaccination guidelines. The IP explained staff COVID vaccination status was required upon hire and kept in the employee file, however the IP did not monitor or track each staff's vaccination status.A CDC document titled COVID-19 Vaccination for Long-term Care Residents dated 06/11/2025, documented most adults ages 18 years and older, including people who work in long-term care (LTC) settings, should receive one dose of an updated COVID-19 vaccine. The CDC recommended two doses of an updated COVID-19 vaccine for everyone ages 65 and older, including those who work in LTC settings.Cross referenced with tags F835 and F887

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, and document review the facility failed to 1) ensure facility staff were screened annually for eligibility to receive a COVID-19 (COVID) vaccine, education regarding the vaccine was provided, and the vaccine was offered and either administered or declined, and 2) failed to develop and implement policies and procedures related to COVID immunizations. This deficient practice had the potential to affect compliance with vaccination requirements and increase the risk of disease transmission. Findings include:On 05/05/2026 at 10:41 AM, the Regional Director of Nursing (Regional DON), who was also the previous Infection Preventionist, was requested to provide documented tracking of staff screened for eligibility to receive a COVID vaccine, provided education related to COVID vaccines, and offered an opportunity to receive or decline vaccination with a COVID vaccine. The Regional DON verbalized the facility had a COVID binder with the information but could not locate the binder.The Regional DON could not provide the requested documentation and explained the Regional DON thought the facility did not have to track the information for staff since the facility did not have to report the information to the National Health and Safety Network (NHSN).On 05/05/2026 at 3:58 PM, the Administrator explained the facility did not require staff to obtain COVID vaccinations and did not know it was still required to be offered. The Administrator verbalized staff were given a flyer about the vaccination clinic to sign up for the clinic but did not document the offering, education, or administration/declination of the staff COVID vaccines.On 05/06/2026 at 1:09 PM, the Regional DON explained staff COVID vaccinations were not documented or tracked as it was a personal choice for staff to receive/decline the vaccination.On 05/06/2026 at 1:31 PM, the Director of Nursing/Infection Preventionist (DON/IP) explained staff COVID vaccination status was collected upon hire but was not tracked or monitored. The DON/IP confirmed the facility followed the Centers for Disease Control and Prevention (CDC) guidelines on infection control and immunizations.The facility could not provide a policy related to COVID-19 immunizations.A CDC document titled COVID-19 Vaccination for Long-term Care Residents dated 06/11/2025, documented most adults ages 18 years and older, including people who worked in long-term care (LTC) settings, should receive one dose of an updated COVID-19 vaccine. The CDC recommended two doses of an updated COVID-19 vaccine for everyone ages 65 and older, including those who worked in LTC settings. Preventing infections in healthcare protected the health and safety of personnel, patients, and visitors.Cross referenced with tag F835

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a Director of Nursing (DON) served at the facility on a full-time basis for 2 of 15 months reviewed for sufficient and competent nurse staffing. This deficient practice had the potential to compromise nursing care received by all residents in the facility.Findings include:On 05/07/2026 at 10:58 AM, the Administrator verbalized the facility's previous DON resigned from the facility in September 2025 and the current DON was appointed in December 2025. The Administrator explained the facility did not have a DON from September to December 2025. On 05/07/2026 at 12:36 PM, the Office Manager verbalized the previous DON resigned from the facility with a final working day of 09/17/2025. The current DON was appointed the DON position with a starting date of 12/01/2025. The Facility assessment dated [DATE] documented the facility required a full time DON working 8 hours per day, 5 days per week and on call 24 hours per day, 7 days per week. The DON job description revised 11/20/2019, documented essential job functions of a DON in addition to supervisory responsibilities included the following:Plan and organize daily functions of the facility.Complete pre-admission resident evaluations at their current place of care.Participate in the development and updating of the interdisciplinary plan of careEnsure compliance with all regulatory guidelines, licensing requirements, and all facility related mentor policies and procedures.Be responsible for hiring, training, evaluating, providing corrective action to and terminating staff.Maintain staffing levels within regulations and budgetary guidelines.Be responsible for the infection control program and the the effective and efficient use of antimicrobials.Manage Licensed Independent Practitioners, independed contractors, and vendor services.Provide and manage continuing education programs.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure 3 of 3 residents participating in the resident council were free from verbal abuse and neglect by Certified Nursing Assistant (CNA1). This deficient practice had the potential to cause psychological harm and expose residents to emotional distress, indignity, and risk of infection due to inadequate hygiene, privacy, and responsiveness.Findings include: On 05/05/2026 at 2:31 PM, during a resident council interview, the residents verbalized the following:-2 of 3 residents have complained to the previous Director of Nursing (DON), current DON and Administrator regarding the care provided by a CNA1. CNA1 only worked at the facility on Sundays.-1 of 3 residents had submitted written grievances regarding CNA1.The resident stated the resident was not informed of any action taken by the facility to address the resident's concerns.-3 of 3 residents agreed CNA1 did not know how to provide proper incontinence care after a bowel movement and did not wear gloves while providing peritoneal care. When told the residents were still not clean, CNA1 responded yes you are.-3 of 3 residents agreed CNA1 yelled down the hallway when a resident needed assistance, utilizing first names and the problem to be addressed. For example, CNA1 yelled, [Resident name] had a bowel movement, exposing the resident's private health information to others in the facility. The facility schedule documented CNA1 worked at the facility on 02/22, 03/01, 03/08, 03/15, 03/22, 03/29, 04/05, 04/12, 04/19, and 04/26/2026.The facility's grievance log lacked documented evidence of grievances filed regarding the care provided by CNA1.On 05/07/2026 at 9:10 AM, CNA2 verbalized abuse could be categorized into physical, mental, and emotional abuse. Refusing to assist a resident, hitting a resident, not proving residents required care, taking a resident's money, and behaving inconsistently toward a resident could constitute abuse. CNA2 verbalized CNA2 would report allegations of abuse immediately to the DON and follow the chain of command. CNA2 was unsure where to document allegations of abuse. CNA2 verbalized being familiar with CNA1 and explained many residents in the facility complained about CNA1's care and have refused to have CNA1 provide care to the residents. CNA2 explained CNA1 did not use gloves while providing peritoneal care, did not clean residents well, left residents in the middle of providing incontinence care and did not return, and put residents at risk of falling. CNA2 observed CNA1 tell a resident if [the resident] stopped eating so much, [the resident] would not be so fat. CNA2 reported the concerns about CNA1 to both the DON and the Administrator, however was unsure whether anything had been done to address the concerns.On 05/07/2026 at 10:25 AM, the DON explained all staff received abuse prevention training upon hire and annually thereafter. Abuse could be categorized into emotional, financial, physical, or sexual abuse in addition to neglect and exploitation. Any mistreatment of a resident could be considered abuse, such as striking at, yelling at or making sexually inappropriate remarks toward a resident. Neglect would be defined as withholding services required to meet a resident need, such as leaving a resident in a soiled brief. Staff were expected to report any alleged abuse to the DON or to the Administrator immediately. The DON explained when an allegation of abuse was reported, the DON and Administrator would work together to investigate the allegation. The alleged staff member would be suspended pending an investigation. Staff would be expected to round frequently on residents, knock on doors prior to entering resident rooms, follow hand hygiene guidelines per the Centers for Disease Control and Prevention (CDC), and follow physician orders as applicable. The DON was unaware of any complaints by staff or residents regarding CNA1's care or any allegations of abuse from CNA1. The DON verbalized one resident requested CNA1 be removed from the resident's care; however since the DON became the DON in December of 2025, CNA1 returned to the resident's care and there had been no further complaints.On 05/07/2026 at 10:58 AM, the Administrator explained staff were expected to immediately report any allegations of abuse to the Administrator. Staff were educated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon hire and regularly throughout the year on abuse prevention. The Administrator defined abuse as the willful infliction of harm and could be physical, mental, or sexual abuse in addition to misappropriation of resident funds, confinement, neglect and abandonment. Neglect was defined as the failure of the facility to provide services to a resident. Examples of abuse included failure to answer a call light, failure to provide incontinence care, and using a resident's money. The Administrator verbalized the Administrator had previously been made aware CNA1 did not use gloves while providing peritoneal care after a resident's bowel movement. The Administrator had also been informed by residents CNA1 was too loud. The Administrator verbalized no written grievances about CNA1 and no allegations of abuse by CNA1 had been reported to the Administrator. Resident #25Resident #25 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and depression, unspecified.On 05/07/2026 at 1:30 PM, Resident #25 verbalized concerns related to care provided by CNA1. Resident #25 recounted on 05/03/2026, when CNA1 provided peritoneal care to the resident, CNA1 wiped Resident #25 without performing hand hygiene or donning gloves. After assisting Resident #25 to get dressed, CNA1 assisted the resident to the resident's wheelchair. The resident noticed feces on the wheelchair armrest and joystick. Resident #25 verbalized being disgusted and upset by the unprofessional care provided. After providing incontinence care to Resident #25, CNA1 began to assist with dinner service. Resident #25 did not observe CNA1 perform hand hygiene. Resident #25 found it disturbing CNA1 would perform incontinence care and then handle resident food without performing hand hygiene. Resident #25 was also concerned with the way CNA1 entered resident rooms. Resident #25 explained when CNA1 knocked on the resident's door, CNA1 would not leave time for a response and would immediately enter the resident's room. The resident verbalized the resident's privacy was compromised. Additionally, when Resident #25 requests assistance, such as a refill of water, CNA1 would leave the room and never return. Resident #25 explained the resident reported the resident's concerns approximately six times to both the DON and the Administrator. Each time, the DON and Administrator informed Resident #25 CNA1 would be retrained. Nonetheless, Resident #25 did not notice a change in CNA1's behavior. Resident #25 resorted to contacting outside agencies hoping to get the resident's concerns addressed. Resident #25 explained the resident would rather not be at the facility than receive care from CNA1.Resident #9Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, single episode unspecified and anxiety disorder, unspecified.On 05/07/2026 at 2:00 PM, Resident #9 verbalized being familiar with CNA1. Resident #9 recalled, approximately one year prior, CNA1 made upsetting comments to the resident. The resident verbalized Resident #9 asked CNA1 to leave the resident's room, and reported the incident to the previous DON. The facility temporarily removed CNA1 from the resident's care. When CNA1 later returned to the resident's care, the resident was informed the facility was short staffed.Resident #9 further stated when the resident used their call light, CNA1 would yell down the hallway identifying the resident by name and announcing the resident's personal needs, such as Resident #9 had a bowel movement. The resident explained feeling embarrassed and believed this compromised the resident's privacy. Resident #9 described CNA1 as displaying outright ignorance to other people's feelings.Resident #12Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of unspecified fracture of the lower end of right radius, subsequent encounter for closed fracture with routine healing.On 05/07/2026 at 2:13 PM, Resident #12 verbalized being familiar with CNA1. Resident #12 explained CNA1 did not pay any attention to the resident. When the resident pressed the resident's call light, CNA1 yelled the resident needs down the hallway and provided minimal assistance. If Resident #12 requested water, CNA1 did not ensure water was provided. If Resident #12's urinal was full, CNA1 emptied without donning gloves, and the urinal was not cleaned and disinfected.The facility policy titled, Abuse-Dependent Adult or Child, revised 01/06/2016, documented abuse included physical abuse, neglect, financial abuse, abandonment, isolation, deprivation by a caregiver of goods and services necessary to avoid (continued on next page)

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	295103	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	3980 Lake Placid Drive Ste 2 Reno, NV 89511

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical harm or mental suffering, and other treatment resulting in physical harm, pain or mental suffering. A mandated reporter was any person working for the facility, including administrators, supervisors, nursing staff, therapists, social workers, dieticians and other support staff. Staff would immediately report all incidents or suspected incidents of resident abuse, mistreatment, neglect or injury of unknown source to the Administrator or DON and correct reporting agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure the environment was free from accident hazards related to the use of side rails for 1 of 12 sampled residents (Resident #11). This deficient practice had the potential to result in serious injury, including entrapment, by placing the resident at risk for preventable harm.Findings include:Resident #11 Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including spastic quadriplegic cerebral palsy, neuromuscular scoliosis of the thoracic region, fusion of spine of the lumbar region and thoracic region, expressive language disorder, and unspecified lack of expected normal physiological development in childhood. On 05/04/2026 at 10:22 AM, Resident #11 was present in the resident's bed. Upper and lower half-length bed rails were enabled in the upright position on the right and left sides of the bed. Resident #11 was squirming in the bed and attempting to fit between the upper and lower bed rails on the left side of the bed. A Side Rail Assessment completed by the Occupational Therapist (OT), dated 04/13/2026, documented the following:Resident #11's representative requested bilateral upper rails for safety, security and increased independence with mobilityIf yes was answered to the following questions, the resident was at higher risk of entrapment and bed side rails were not recommended. No was selected for mobility impairment, unusually small or large head, considered to be underweight, and impulsivity. Yes was selected under cognitive impairment.Resident #11 required assistance with repositioning.No previous interventions were documented.Accident hazards were not identified as a risk. The resident could attempt to climb over, around, or between rails, exit the bed in an unsafe manner, or be at risk for getting caught between the rails or the rails and mattress.Resident family requested bilateral upper rails for safety and security. The famility was educated on risks and benefits. The resident was at low risk for entrapment with upper rails only.A Developmental Bed Assessment completed by the OT, dated 04/13/2026, documented the following:Resident #11's representative requested bilateral upper rails for safety and security.Resident #11 had spinal precautions, self-stimulatory behaviors and impulsivity. Resident #11 was at risk for limb entrapment and was independent of rolling and functional position changes.No previous interventions were documented.Resident family requested bilateral upper rails for safety and security. The famility was educated on risks and benefits. The resident was at low risk for entrapment with upper rails only.A physician's order, dated 04/13/2026, documented bilateral upper side rails up while in bed. Check every two hours for safety. Resident #11's Care Plan included an intervention, revised 04/13/2026, documenting the use of bilateral upper rails as requested by the resident's representative and per physician's orders for safety during care provision and at all times to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition every two hours and as necessary to avoid injury. On 05/06/2026 at 10:23 AM, a Licensed Practical Nurse (LPN) verbalized occupational therapy was responsible for determining whether side rails were appropriate for resident use The LPN explained risk factors to consider for side rail use included falls from climbing over the side rails, suffocation, and entanglement. Nursing staff were to monitor residents with bed rails and regularly assess residents for bed rail appropriateness. Every two hours, staff were expected to ensure resident bed rail use was appropriate per the physician's orders. The LPN explained Resident #11's perception of danger was impaired and used upper and lower side rails. The LPN was unsure whether alternative interventions were attempted prior to side rail installation. On 05/07/2026 at 8:17 AM, the OT verbalized when determining whether bed rails would be appropriate for resident use, the OT would ensure the resident was cognitively intact, able to communicate and use the call light, and had a reasonable cause for use. Upper rails could be used; however lower rails could be problematic due to the risk of entrapment between the upper and lower rails. Risks of bed rail use included lethargy, involuntary movement, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impulsivity, cognitive impairment and being underweight. The OT explained the biggest risk factors of bed rail use were impaired cognition and impulsivity as residents could attempt to climb over the bed rails. Alternate interventions should be attempted prior to bed rail installation. The OT expected nursing staff to monitor residents to ensure residents were not entrapped. When Resident #11 was admitted to the facility, the resident's representative requested side rails be installed. Bilateral upper side rails were ordered for Resident #11. Resident #11's representative often enabled the lower side rails and had been educated by the facility to only enable the upper side rails. The OT confirmed the OT completed both the side rail assessment and developmental bed assessment and acknowledged the inconsistencies. The OT was unable to confirm whether, at the time of the assessments, Resident #11 was impulsive and required bed mobility assistance. The OT confirmed cognitive impairment would increase the risk for entrapment. The OT verbalized no alternative interventions were attempted prior to installing bed rails and a floor bed should have been the first intervention. On 05/07/2026 at 10:42 AM, the Director of Nursing (DON) verbalized the interdisciplinary team determined whether a resident was safe to use side rails. Upon admission, a resident would be assessed for bed rail use. Residents would need to be alert and oriented and request the side rails for mobility independence. Risks associated with side rail use included accidental self-harm and falls off the enabled side rails with the potential to result in serious injury, harm or death. Resident #11's strength and mobility increased, and the resident was able to roll and get up independently. Resident #11's representative requested a bed with side rails in order to simulate an environment similar to the resident's home. The DON explained Resident #11's physician ordered bilateral upper side rails. At no time should the lower side rails be enabled. The DON verbalized Resident #11's representative often enabled the resident's lower side rails, and the facility discussed the risks of using both the upper and lower side rails with the representative. The DON verbalized the representative may have required additional education. The facility policy titled, Bed Rails, revised 07/18/2024, documented the use of bed rails or side rails was prohibited unless the criteria for use of bed rails had been met, including attempts to use alternative interdisciplinary evaluation, resident assessment, and informed consent. Prior to the installation or use of a side rail or bed rail, alternatives to the use of side or bed rails would be attempted. A resident side rail assessment would be used to determine the risk for entrapment. The resident assessment also determined potential risk to the resident associated with the use of bed rails, including accident hazards. Residents could attempt to climb over, around, between, or through the rails. A resident or part of their body could be caught between rails, the opening of the rails, or between the bed rails and mattress.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and document review, the facility failed to maintain accurate controlled drug records (CDR) for 1 of 12 sampled residents (Resident #5) in 1 of 2 reviewed narcotic logs books. This deficient practice had the potential to result in medication errors, inaccurate documentation of controlled substances, and increased risk of harm to residents due to improper handling of medications.Findings include:Resident #5Resident #5 was admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, anoxic brain damage, not elsewhere classified, tracheostomy status, gastrostomy status, and cerebral infarction, unspecified.A physician order dated 04/23/2026, documented lacosamide oral tablet,100 milligrams (mg), give one tablet via gastric tube (g-tube) two times per day for seizures. The medication was a controlled substance. A physician order dated 05/01/2026, documented clobazam oral suspension, 10 mg /4 milliliters (ml), give 8 ml via g-tube every 12 hours for seizures. The medication was a controlled substance. On 05/07/2026 at 12:30 PM, a CDR documented Resident #5 was last administered one100 mg tablet of lacosamide at 8:50 PM on 05/06/2026, and the remaining count was 10 tablets. A total of 10 tablets remained in the medications blister pack (a card containing individually sealed doses of a medication). The CDR did not include an entry for the 05/07/2026 AM dose of lacosamide.On 05/07/2026 at 12:30 PM, a CDR documented Resident #5 was last administered 8 ml of clobazam on 05/06/2026 at 8:50 PM. The bottle of clobazam did not have graduation/measurement marks on the bottle making it difficult to determine the approximate amount of medication remaining in the bottle. The CDR did not include an entry for the 05/07/2026 AM dose of clobazam.On 05/07/2026 at 12:34 PM, the Director of Nursing (DON) verbalized the DON had first become aware of the lack of graduation/measurement marks on the bottle of clobazam on 05/06/2026. The DON confirmed the bottle of clobazam should have included graduation/measurement marks to assist nurses in identifying the amount of clobazam remaining in the bottle after each administration. The DON confirmed the DON had not contacted the pharmacy/pharmacist to discuss a solution.On 05/07/2026 at 12:45 PM, a Licensed Practical Nurse (LPN) explained the LPN was behind on administering AM medications to the residents and had not given Resident #5 the resident's AM (morning) dose of Lacosamide. Resident #5's Medication Administration Record (MAR) for May 2026, documented lacosamide had been administered to Resident #5 during the morning of 05/07/2026. However, the LPN confirmed the LPN had documented the medication as administered but had not given the medication to the resident.On 05/07/2026, the DON verbalized the DON did not know when nurses should document a medication and update the remaining quantity in the CDR when a controlled medication was administered.The facility policy titled Inventory Control of Controlled Substances revised on 08/01/2024, documented the facility routinely reconciled the number of doses remaining in the package to the number of doses recorded on the CDR to the MAR. The facility ensured facility staff counted all Schedule III-IV controlled substances in accordance with facility policy and applicable law. The policy did not include a process for maintaining Controlled Substance Logbooks including documenting when a medication was administered and reconciliation of medications with the oncoming nurse and the off-going nurse.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and document review, the facility failed to ensure behavior and side effect monitoring for psychotropic medication was completed for 1 of 12 sampled residents (Resident #18), and failed to ensure an order for pregabalin (a nerve pain medication) was not entered twice in the resident's set of active medication orders and Medication Administration Record (MAR) for 1 of 12 sampled residents (Resident #9). This deficient practice had the potential to result in medication errors and cause physical harm to the resident. Findings include: Resident #18 Resident #18 admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including major depressive disorder, recurrent, restlessness and agitation, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence, and generalized anxiety disorder. A physician order dated 10/17/2025, documented risperidone oral tablet 1 milligram (mg), give 1 mg via gastrostomy tube (G-tube) three times a day for behavior disorder. Discontinued 04/28/2025. A physician order dated 08/01/2025, documented sertraline hydrochloride oral tablet, give 200 mg via g-tube one time a day for anxiety. A physician order dated 08/01/2025, documented antianxiety medication, monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. A physician order dated 02/19/2026, documented behavior monitoring (kicking/hitting, threats of physical harm, or name calling) for risperidone as needed for behavior monitoring, use side effect codes. A physician order dated 02/26/2026, documented antipsychotic side effect monitoring every shift. A physician order dated 02/26/2026, documented behavior monitoring for antipsychotic (risperidone) every shift for behavior monitoring generalized anxiety disorder. A physician order dated 04/28/2025, documented risperidone oral tablet 1 mg, give 2 mg via g-tube one time a day for generalized anxiety disorder at noon while at school, and give 0.5 mg via g-tube two times a day for generalized anxiety disorder. A care plan focus initiated on 09/17/2024, and revised on 04/06/2026, documented Resident #18 had behavioral problems such as agitation, poor safety awareness, self-harm (of banging head into floor and on wall) and outburst/meltdowns-cussing and yelling at staff. Interventions included administering medications as ordered and monitor for side effects and effectiveness. A care plan focus initiated on 03/05/2024, and revised on 02/22/2026, documented Resident #18 used psychotropic and antipsychotic medications related to diagnosis of behavioral and emotional disorders with onset occurring in childhood and adolescence, depression, restlessness, and agitation. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following interventions were documented: -Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift and as needed. -Monitor/document/report as needed any adverse reactions of psychotropic medications. -Monitor/record occurrence of target behavior symptoms (inappropriate response to verbal communication, violence/aggression towards staff/others) and document per facility protocol. A Treatment Administration Record (TAR) dated 02/01/2026-02/28/2026, lacked documentation of the side effect and behavior monitoring for the use of antipsychotic medication and antidepressant medication during the night shift (7 PM – 7 AM) for 02/19/2026. A TAR dated 03/01/2026-03/31/2026, lacked documentation of the side effect and behavior monitoring for antidepressant medication and antipsychotic medication during the day shift (7 AM – 7 PM shift) for 03/30/2026. A TAR dated 04/01/2026-04/30/2026, lacked documentation of the side effect and behavior monitoring for the use of antipsychotic medication and antidepressant medication during the night shift for 04/08/2026. A TAR dated 05/01/2026-05/31/2026, lacked documentation of the side effect and behavior monitoring for the use of antipsychotic medication and antidepressant medication during the night shift for 05/04/2026. On 05/06/2026 at 11:26 AM, the Regional Director of Nursing Support (Regional DON) explained side effect and behavior monitoring related to an administered medication should be documented on the TAR. If the TAR was blank on a date it meant the behavior or side effect monitoring was not done. On 05/06/2026 at 2:34 PM, the Director of Nursing (DON) explained the DON expected nursing staff to document behaviors and side effect monitoring daily and per the physician order. The DON would expect the behavior/side effect monitoring to be documented on the TAR. On 05/07/2026 at 1:23 PM, the Regional DON confirmed the blank dates for side effects and behavior monitoring were missing documentation for 02/19/2026, 03/30/2026, 04/08/2026, and 05/04/2026 for Resident #18. The Regional DON explained nursing was required to document on the TAR. The facility policy titled Psychotherapeutic Medications, revised 03/21/2025, documented categories of psychotherapeutic medications included antipsychotic, antidepressant, hypnotic, and antianxiety/sedative medications. The occurrence of behaviors for which psychotherapeutic medications were used would be documented every shift on the TAR. The pharmacy policy titled 3.8 Psychotropic Medication Use, revised 03/01/2025, documented all medications used to treat behaviors should be monitored for efficacy, risks, benefits, and harm/adverse consequences. Facility staff should monitor the resident's behavior pursuant to facility policy. Resident #9 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of chronic pain syndrome. A physician order dated 03/07/2026, documented pregabalin 75 mg capsule, give by mouth two times a day for chronic pain management. The order did not include a stop date and was documented as an active order. A physician order dated 05/05/2026, documented pregabalin 75 mg capsule, give by mouth two times a day for chronic pain management. The order did not include a stop date and was documented as an active order. Resident #9's MAR for May 2026, documented pregabalin 75 mg capsules, give one by mouth twice daily at 9:00 AM and 9:00 PM for chronic pain. The order was an active order and had a start date of 03/07/2026 and did not include a stop/end date. Resident #9's MAR for May 2026, documented pregabalin 75 mg capsules, give one by mouth twice daily at 9:00 AM and 9:00 PM for chronic pain. The order was an active order and had a start date of 05/05/2026 and did not include a stop/end date. On 05/06/2026 at 10:34 AM, the DON confirmed Resident #9's physician orders included two identical orders for pregabalin ordered on 03/07/2026, and again on 05/05/2026. The DON confirmed both orders for the medication remained on the resident's MAR. The DON confirmed when the second order for pregabalin was entered into to the resident's order set and MAR, the previous orders should have been discontinued and removed from the MAR. On 05/06/2026 at 10:41 AM, the DON confirmed having an order listed as active in the order set and on the MAR twice was a concern because it put the resident at risk of receiving the medication twice. The DON verbalized the concerns with any medication being double dosed was an increased risk for adverse reactions and side effects. The potential adverse side effects of pregabalin included increased neurological reactions, depressed respirations, and any other potential side effect of the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to ensure resident food items placed in refrigeration were appropriately labeled and dated. These deficient processes have the potential to result in consumption of expired food, and increased risk of illness for residents. On 05/04/2026 at 09:25 AM, during pediatric section satellite kitchen inspection, resident food, including a take-out container with accoutrements and quart of milk with no visible placement date or use by date were observed on the top shelf of the refrigerator. Although no food containers were marked, a placard placed in front of the food items provided a resident name and room number. An uncovered partially consumed ice cream type product was contained in a cup in the freezer. There was no visible resident name, placement date, or use by date information on the cup.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and document review, the facility failed to ensure Administration: (1) verified the Infection Preventionist (IP) possessed the required training and competency to effectively educate, track, and monitor staff COVIDˆ19 (COVID) vaccinations, and (2) ensured staff were screened for eligibility, provided education on the COVID vaccine, and offered the vaccine with documentation of acceptance or declination. This deficient practice placed the resident population at increased risk of exposure to and infection from COVID. Findings include: Infection PreventionistOn 05/05/2026 at 10:41 AM, the Regional Director of Nursing (Regional DON), who was also the previous IP, provided the Infection Control Manual to survey team. The manual did not include COVID staff infection monitoring, staff immunizations, or resident care related to COVID. On 05/06/2026 at 1:32 PM, the Director of Nursing/IP (DON/IP) confirmed the facility followed the Centers for Disease Control and Prevention (CDC) guidelines, however the DON/IP did not know which guidelines were appropriate for COVID staff vaccinations, and did not review and/or revise the Infection Control Program to include resident or staff COVID education, immunization, or resident care.The facility job description titled Infection Preventionist, dated 06/24/2019, documented the IP was responsible for the effective management and operation of the infection prevention program, including the education of facility staff members. The IP utilized evidence-based practices such as those published by the CDC. The IP conducted educational activities for healthcare workers through instructions and dissemination of information on healthcare practices.COVID VaccinationsOn 05/05/2026 at 3:58 PM, the Administrator confirmed the facility did not require staff to get COVID vaccinations. Staff were handed an informational flyer regarding a sign up for a facility vaccination clinic provided by a local pharmacy. The Administrator explained the education, offering, and monitoring of the staff COVID vaccinations was not documented and did not know it was required.On 05/06/2026 at 1:31 PM, the DON/IP confirmed the DON/IP did not have documentation staff were screened for eligibility to receive a COVID vaccination and/or a booster vaccine, education regarding the vaccine was provided, and if the vaccine was offered and either administered or declined. The DON/IP verbalized the facility followed CDC infection control and vaccination guidelines. The IP explained staff COVID vaccination status was required upon hire and in the employee file, however the IP did not monitor or track each staff's vaccination status. On 05/06/2026 at 1:09 PM, the Regional DON explained COVID vaccinations were offered to staff with other vaccination offerings when the facility provided a staff vaccination clinic and were not documented or tracked as it was staff's personal choice to get the vaccination. The Regional DON verbalized all staff were required to provide proof of COVID vaccination upon hire but did not track the vaccinations beyond the hire date. The Regional DON explained the facility should have tracked and documented staff vaccinations.Cross referenced with tags F882 and F 887

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	295103	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caremeridian Llc, Dba Neurorestorative	3980 Lake Placid Drive Ste 2 Reno, NV 89511

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, clinical record review, and document review, the facility failed to ensure the Facility Assessment (FA) was accurate and included nicotine dependence and addiction with the facility's common diagnoses and conditions. This deficient practice had the potential to result in facility staff not receiving adequate training on the care of residents with nicotine dependence and addiction diagnoses and the needs of those residents not being met.Findings include:During the entrance conference with the facility on 05/04/2026, a list of residents who smoke residing in the facility was provided by the facility.The list identified three residents as smokers, including one resident who was a vaper, which was technically distinct from smoking. The designated smoking location was off the main entrance parking lot which resident smokers accessed by exiting the facilities main entrance.The current Facility Assessment, dated 01/08/2026, did not include nicotine abuse or addiction nor a list of the number of active or current substance abuse disorders.On 05/07/2026 at 3:27 PM, the Director of Nursing (DON) verbalized the DON was involved with completing the FA but at the time of FA development the facility had only one intermittent smoker. The DON confirmed nicotine addiction was not identified on the FA as a diagnosis in the facility and the FA lacked documented evidence of the number of residents with active or current substance use disorders. The DON confirmed three residents in the facility were current cigarette smokers/ vapers.The Centers for Disease Control and Prevention article titled Treatment of Substance Use Disorders, dated 04/25/2024, documented a substance use disorder was a treatable, chronic disease and could range in severity from moderate to severe. A substance use disorder could be applied to many types of drugs including tobacco (nicotine).

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on observation, interview, and document review, the Quality Assurance and Process Improvement (QAPI) committee failed to identify the QAPI committee did not include the required members.Findings include: On 05/06/2026, the facility provided the sign in sheet of QAPI Committee members present at the Performance Improvement Committee Meeting dated 01/29/2026, documenting the QAPI committee was comprised of the Administrator, the Director of Nursing (DON), Director of Rehabilitation, Maintenance Director, Medical Director, and direct care staff. There was not an Infection Preventionist (IP) in attendance of the meeting. On 05/07/2026 at 3:54 PM, the Administrator verbalized the facility did not have the Infection Preventionist at the QAPI meeting on 01/29/2026. The Administrator confirmed the facility did not have all of the required members involved in the QAPI meeting when the IP did not attend the first quarter of 2026 QAPI meeting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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) Isolation Precautions were implemented according to facility policy and Centers for Disease Control and Prevention (CDC) recommendations for 1 of 12 sampled residents (Resident #15), and 2) the Infection Prevention and Control Plan (IPCP) included all of the required elements. These deficient practices had the potential to increase the risk of spreading infectious organisms throughout the facility.Findings include: Isolation Precautions Resident #15 Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of chronic respiratory failure with hypoxia. A physician's order dated 05/03/2026, documented Isolation Precautions for seven days for human rhinovirus or enterovirus or until symptoms resolve every shift for upper respiratory infection (URI) isolation for seven days. A Care Plan focus revised 05/04/2026, documented Resident #15 was on Droplet Precautions related to having tested positive for rhinovirus and enterovirus. A Care Plan intervention initiated 05/04/2026 documented all staff and visitors would follow Droplet Precautions when entering and exiting Resident #15's room. On 05/04/2026 at 10:02 AM, Enhanced Barrier Precautions (EBP) signage was posted at the entrance of Resident #15's room. The sign documented everyone must clean hands before entering and when exiting the room. On 05/04/2026 at 10:09 AM, a Respiratory Therapist (RT) verbalized Resident #15 recently tested positive for rhinovirus. The RT acknowledged the EBP signage present at the entrance of Resident #15's room and verbalized Resident #15 should be on Isolation Precautions to include mask usage by all staff and visitors upon entering Resident #15's room. The RT was unsure who was responsible to ensure appropriate infection control signage was posted at the entrance of applicable rooms. On 05/04/2026 at 10:18 AM, the Director of Nursing (DON) replaced the EBP signage at the entrance of Resident #15's room with Droplet Precautions signage. The DON verbalized Droplet Precautions were ordered by the physician on 05/03/2026 and new signage was required. On 05/07/2026 at 11:37 AM, a Registered Nurse (RN) explained Resident #15 tested positive for rhinovirus on 05/03/2026 and should have immediately been put on isolation precautions to last seven days or until symptoms resolve. The RN explained droplet precautions required staff to don a mask, gown and gloves upon entrance to Resident #15's room to prevent the spread of an infectious disease. The RN verbalized there were four residents in the facility with an active rhinovirus infection. On 05/07/2026 at 1:46 PM, the DON verbalized EBP were used for residents at high risk of infection while Isolation Precautions were used for residents with an active infection. The DON explained Droplet Precautions were a category of Isolation Precautions and required the use of gowns, gloves, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	masks, and eye protection when caring for residents. The DON verbalized four residents in the facility had an active rhinovirus infection, including Resident #15. Resident #15's physician ordered Isolation Precautions be implemented on 05/03/2026. The DON explained nursing staff were expected to post precaution signage immediately upon receiving a physician's order. The facility policy titled, Droplet Precautions, dated 01/2007, documented Droplet Precautions would be used in addition to Standard Precautions for resident with infections which could be transmitted by droplets. The CDC document titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated 09/2024, documented respiratory droplets were generated when an infected person coughed, sneezed, or talked. Rhinovirus was one example of an infectious agent transmitted via the droplet route. Standard and Droplet Precautions would be implemented for rhinovirus and healthcare personnel would be expected to don a mask upon room entry. IPCP On 05/05/2026 at 10:41 AM, the Regional Director of Nursing (Regional DON), who was also the previous Infection Preventionist (IP), provided the Infection Control Manual to the survey team. The manual did not include COVID staff immunizations, staff work restrictions, or resident care related to COVID. The Regional DON explained the Regional DON thought since the facility was not required to report staff COVID vaccination status to the National Healthcare and Safety Network (NHSN) any longer, the facility did not have to track the staff immunizations. The Regional DON could not provide the requested documentation or policies related to COVID. On 05/06/2026 at 1:32 PM, the Director of Nursing/Infection Preventionist (DON/IP) confirmed the facility followed the CDC guidelines, however the DON/IP did not know which guidelines were appropriate for COVID staff vaccinations, and did not review and/or revise the Infection Control Program to include resident or staff COVID education, immunization, or care. The DON/IP was not able to locate a facility policy related to COVID for staff or residents. A CDC document titled, Core Infection Prevention and Control Practices, dated 04/12/2024, documented adherence to infection prevention and control practices was essential to providing safe and high-quality patient care across all settings where healthcare is delivered. The facility should develop and implement systems for early detection and management of potentially infectious persons to include use of appropriate infection control measures, isolation precautions, use of personal protective equipment, cleaning materials, laundry processing, and at the time of admission to long-term care facilities. A CDC document titled Infection Control Guidance: SARS-CoV-2, revised 06/24/2024, documented healthcare facilities should have a plan for how SARS-CoV-2 (COVID-19) exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. Everyone should be encouraged to remain up to date with all recommended COVID-19 vaccine doses. Cross-reference with F835, F882, and F887

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview, personnel record review, and document review, the facility failed to ensure elder abuse prevention training was completed timely for 2 of 19 sampled employees (Employee #5 and #11). This deficient practice had the potential to place all residents at risk for abuse and neglect.Findings include: Employee #5Employee #5 was hired as a Registered Dietician on 01/07/2025.Employee #5's personnel record included initial abuse prevention training completed on 01/07/2025, and annual abuse prevention training completed on 01/14/2026, 7 days late.Employee #11Employee #11 was hired as a Registered Nurse (RN), hire date unknown.Employee #11's personnel record lacked documented evidence of abuse prevention training.On 05/06/2026 at 9:06 AM, the Office Manager (OM) verbalized all staff were required to complete abuse prevention training initially upon hire and annually by the anniversary date. The OM verbalized the OM was unable to identify when Employee #11 started at the facility, however confirmed Employee #11 worked in the facility with resident contact. The OM confirmed Employee #11's personnel record lacked documented evidence of abuse prevention training. The OM confirmed Employee #5 completed abuse prevention training late.The facility policy titled, Abuse-Dependent Adult or Child, revised 01/06/20216, documented education and training would be conducted to all healthcare workers during orientation, annually and as needed on issues related to abuse prohibition practices such as the seven components of abuse, how to identify risk factors and victims of abuse, what constituted abuse, neglect and misappropriation of resident property, abuse prevention, and appropriate intervention and follow-up.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview, personnel record review, and document review, the facility failed to ensure behavioral health care training was completed timely for 3 of 19 sampled employees (Employee #5, #11, and #16). This deficient practice had the potential to prevent residents with behavioral health care needs from attaining or maintaining their highest practicable physical, mental and psychosocial well-being.Findings include:Employee #5Employee #5 was hired as a Registered Dietician on 01/07/2025.Employee #5's personnel record included initial behavioral health care training completed on 01/07/2025, and annual behavioral health care training completed on 01/14/2026, 7 days late.Employee #11Employee #11 was hired as a Registered Nurse (RN), hire date unknown.Employee #11's personnel record lacked documented evidence of behavioral health care training.Employee #16Employee #16 was hired as a Certified Nursing Assistant (CNA) on 07/01/2025.Employee #16's personnel record included initial behavioral health care training completed 12/30/2025, 152 days lateOn 05/06/2026 at 9:06 AM, the Office Manager (OM) verbalized all staff were required to complete eight hours of dementia care training (behavioral health care training) initially upon hire and four hours of behavioral health care training annually by the anniversary date. The OM verbalized the OM was unable to identify when Employee #11 started working at the facility, however confirmed Employee #11 worked in the facility with resident contact. The OM confirmed Employee #11's personnel record lacked behavioral health care training. The OM confirmed Employees #5 and #16 completed behavioral health care training late.The facility policy titled, Abuse-Dependent Adult or Child, revised 01/06/2016, documented education and training would be conducted to all healthcare workers during orientation, annually and as needed related to understanding the behavior of residents with dementia and/or cognitive impairments.