STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295104	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Basin Post Acute	1001 N. Mountain Street Carson City, NV 89703

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to report an allegation of staff-to-resident physical abuse for 1 of 18 sampled residents (Resident #24). This deficient practice could allow allegations of abuse to occur and not be reported for investigation resulting in continued or worsening abuse of vulnerable residents throughout the facility.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], with diagnoses including fracture of left femur, fracture around internal prosthetic left hip joint, and chronic obstructive pulmonary disease.On 03/09/2026 at 12:00 PM, Resident #24 verbalized a Certified Nursing Assistant (CNA) had handled the resident roughly and the resident was concerned the CNA would cause further injury to an existing fracture in the resident's hip. Resident #24 had requested the Physical Therapy Assistant (PTA) to remove the CNA from the resident's care due to the CNA handling the resident roughly when providing care. The resident verbalized feeling unsafe as the CNA continued to enter the resident's room to provide care to the resident's roommate.A Physical Therapy Treatment Encounter Note dated 03/08/2026 at 6:26 PM, documented Resident #24 requested to speak with a supervisor and verbalized a CNA had been rough with the resident. A Registered Nurse (RN)/Weekend Nurse Manager (WNM) was notified.On 03/11/2026 at 1:33 PM, the Physical Therapy Director (PT Director) defined abuse as being physically or verbally harmful and withholding care needed to meet basic human rights. Any willful and harmful emotional, physical, or sexual act would constitute abuse. The PT Director confirmed treating a resident roughly could be considered abuse. The PT Director recalled the PT Director had been notified on 03/08/2026, Resident #24 had informed the PTA a CNA was rough with the resident. The PT Director notified the Director of Nursing (DON) of the incident via text message between the PT Director and the DON's personal cellular phones. The DON responded and directed the PT Director to notify the WNM on staff and to educate the resident on how to file a grievance. The PT Director notified the WNM of the resident's allegation.The PT Director was unwilling to provide the documentation of correspondence with the DON of the reporting of the allegation due to its location being on a personal cell phone device. On 03/11/2026 at 2:44 PM, the Resident Care Manager (RCM) defined physical abuse as kicking, hitting, pulling, and providing care in a rough manner. The RCM verbalized the PT Director notified the RCM of the physical abuse allegation on 03/11/2026 and the RCM had been previously unaware. The RCM indicated the CNA providing care for Resident #24 on 03/08/2026 was still working in the facility and was providing care to residents on 03/11/2026.On 03/11/2026 at 2:57 PM, the CNA verbalized on the morning of 03/08/2026, the CNA entered Resident #24's room to provide care and the resident refused. After assisting three other residents the CNA noticed Resident #24's call light was on. The resident was upset with the CNA, and the CNA notified the WNM. The CNA requested to be removed from the resident's care but continued to provide care to the roommate. The CNA was not aware of any allegation of treating the resident roughly until the afternoon of 03/11/2026.On 03/11/2026 at 3:31 PM, the DON verbalized the DON had been notified of the allegation by the PT Director on 03/08/2026 at 12:08 PM and requested the WNM to obtain a statement from the resident. The DON verbalized the WNM had informed the DON the (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	resident had alleged the CNA providing care to Resident #24 moved too quickly when transferring the resident and the resident did not believe the CNA understood proper care for a fractured hip. The DON verbalized the only statement collected was a verbal statement from the WNM. The DON explained having difficulty locating the verbal statement as the DON preferred to document on the DON's personal laptop. Upon retrieval of the WNM's statement, the DON confirmed the statement was not signed or dated by the WNM. The DON confirmed lack of reporting to the resident's family, or the required State agencies.On 03/12/2026 at 8:51 AM, the WNM defined abuse as causing harm to an individual through physical, verbal, mental, or sexual abuse. The WNM gave the examples of name calling, being too rough, behaving aggressively, or anything causing a resident to feel unsafe. The WNM stated Resident #24 had a fracture in the resident's left femur and required assistance with transfers. The WNM conducted a full conversation with the resident, and the resident had felt the CNA was rough and transferred the resident too quickly. The CNA was removed from the resident's care but was allowed to continue to care for the resident's roommate. The WNM verbalized the CNA should have been removed from the resident's area. The WNM verbalized an allegation of physical abuse constituted temporary suspension of the alleged perpetrator until the conclusion of an investigation. The WNM verbalized the WNM should have included the Abuse Coordinator in reporting the allegation, but this had not been completed. The WNM stated statements should have been collected from all parties involved, but this had not been completed.On 03/12/2026 at 2:49 PM, the Abuse Coordinator/Administrator verbalized when the Abuse Coordinator was not available the DON acted as the designee. When an allegation of abuse was reported the suspected staff member would be suspended immediately until reporting was concluded. Written statements would be collected from all parties involved. The Administrator verbalized, If an allegation appears to be unfounded, I am not sure a preliminary investigation needs to be provided or recorded. The Administrator confirmed the allegation of abuse was not reported to the required State agencies.A facility policy titled, Resident Rights, revised December 2016, documented employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence, be treated with respect, kindness, and dignity. Be free from abuse, neglect, misappropriation of property, and exploitation.A facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation, Prevention Program, revised April 2021, documented residents had the right to be free from abuse, neglect, misappropriation, of resident property and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse. The facility would investigate and report any allegations within the timeframe required by federal requirements.A facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation, Reporting and Investigating, revised April 2021, documented all reports of resident abuse, neglect, exploitation were reported to local, state, and federal agencies as required by current regulations and thoroughly investigated by facility management. Findings of all investigations were documented and reported. If a resident abuse, neglect exploitation, or injury was suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. The Administrator of the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility, the local state ombudsman, the resident's representative, and adult protective services. Immediately it was defined as within two hours of an allegation involving abuse, within 24 hours of an allegation that does not involve abuse. Cross reference with F610, and F842

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure 2 of 18 sampled residents (Residents #6 and #14) had an appropriate diagnosis to support the use of an antipsychotic medication. This deficient practice had the potential to result in the use of an unnecessary psychotropic medication and to restrict a resident's ability to function.Findings include:Resident #6 Resident #6 was admitted to the facility on [DATE], with a diagnosis of unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A physician's order dated 02/16/2026, documented Quetiapine Fumarate oral tablet 50 milligrams (mg). Give 50 mg by mouth at bedtime for behaviors. A progress note dated 02/18/2026 at 12:00 AM, documented Quetiapine Fumarate oral tablet 50 mg. Give 50 mg by mouth at bedtime for dementia. A medication regimen review form dated 02/18/2026, documented Resident #6 received the antipsychotic Quetiapine Fumarate for behaviors. An antipsychotic medication should be used only for an appropriate diagnosis as determined by the Centers for Medicare and Medicaid Services (CMS) guidelines. The physician used the medication for an alternate diagnosis, unspecified, and behavioral symptoms presented a danger to the resident or to others. On 03/12/2026 at 11:10 AM, a Certified Nursing Assistant (CNA) verbalized the CNA was assigned to Resident #6 and was familiar with the resident's care. The CNA verbalized being unaware of any behaviors to include hallucinations, delusions, yelling out, or any other physically or verbally aggressive behavior. On 03/12/2026 at 11:20 AM, a Licensed Practical Nurse (LPN) verbalized the LPN was familiar with Resident #6's care needs. The LPN explained resident #6 had a diagnosis of dementia and sometimes exhibited signs of hallucinations such as preparing to make children breakfast. The LPN verbalized the LPN was unaware of any physically or verbally aggressive behavior by Resident #6. The LPN confirmed Resident #6's clinical record included a physician's order for Quetiapine Fumarate at bedtime for behaviors. On 03/12/2026 at 1:04 PM, the Director of Nursing (DON) verbalized the facility ensured pharmacy interventions were used only when clinically indicated through medication regimen reviews. The DON reviewed Resident #6's clinical record and explained Quetiapine Fumarate, an antipsychotic, was ordered for behaviors. The DON was unable to specify what behaviors were being targeted. The DON verbalized expecting a diagnosis associated with psychotropic medication. The DON verbalized a progress note dated 02/18/2026, documented the Quetiapine Fumarate was ordered for dementia. The DON explained neither behaviors nor a diagnosis of dementia would be appropriate indications of use for an antipsychotic medication. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including dementia in other (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, and Alzheimer's disease, unspecified. On 03/09/2026 at 11:00 AM, Resident #14 was sleeping in bed at the lowest position. A physician order dated 02/05/2026, documented Risperidone 0.25 mg, one tablet by mouth two times a day, for a diagnosis of dementia. A medication regimen review form dated 02/18/2026, documented this resident is receiving the antipsychotic for Risperdal. An antipsychotic medication should be used only for an appropriate diagnosis as determined by CMS regulations. The physician selected a diagnosis of schizoaffective disorder for the resident's use of Risperidone. On 03/11/2026 at 2:09 PM, the DON explained Risperidone was an antipsychotic medication and would not be used solely for a diagnosis of dementia. The DON verbalized the pharmacy review was reviewed by the physician and documented schizoaffective disorder as the diagnosis for the resident receiving risperidone; however, the facility was unable to determine where the physician obtained the diagnosis and could not determine the clinical rationale for the order. On 03/12/2026 at 8:16 AM, the Physician verbalized when residents were admitted with antipsychotic medications, the Physician evaluated whether the medication was prescribed in the hospital or brought from home. The Physician stated if the medication was brought from home, the resident's primary care provider continued the evaluation; however, if the medication was prescribed in the hospital, the Physician reviewed the necessity of the medication. The Physician confirmed risperidone was prescribed for dementia and confirmed Resident #14 did not have a diagnosis of schizoaffective disorder. The facility policy titled Psychotropic Medication Use, undated, documented psychotropic medication management was an interdisciplinary process involving the resident, family, and or the representative and included determining adequate indication of usage. Adequate indication for uses referred to the identified documented clinical rationale for administering the medication. A diagnosis alone did not necessarily warrant the use of psychotropic medications.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to investigate an allegation of staff-to-resident physical abuse for 1 of 18 sampled residents (Resident #24). This deficient practice could allow allegations of abuse to occur and result in continued or worsening abuse of vulnerable residents throughout the facility.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], with diagnoses including fracture of left femur, fracture around internal prosthetic left hip joint, and chronic obstructive pulmonary disease.On 03/09/2026 at 12:00 PM, Resident #24 verbalized a Certified Nursing Assistant (CNA) had handled the resident roughly and the resident was concerned the CNA would cause further injury to an existing fracture in the resident's hip. Resident #24 had requested the Physical Therapy Assistant (PTA) remove the CNA from the resident's care due to the CNA handling the resident roughly when providing care. The resident verbalized feeling unsafe as the CNA continued to enter the resident's room to provide care to the resident's roommate.A Physical Therapy Treatment Encounter Note dated 03/08/2026 at 06:26 PM, documented Resident #24 requested to speak with a supervisor and verbalized a CNA had been rough with the resident. A Registered Nurse (RN)/Weekend Nurse Manager (WNM) was notified.On 03/11/2026 at 1:33 PM, the Physical Therapy Director (PT Director) defined abuse as being physically or verbally harmful and withholding care needed to meet basic human rights. Any willful and harmful emotional, physical, or sexual act would constitute abuse. The PT Director confirmed treating a resident roughly could be considered abuse. The PT Director recalled the PT Director had been notified on 03/08/2026, Resident #24 had informed the PTA a CNA was rough with the resident. The PT Director notified the Director of Nursing (DON) of the incident via text message between the PT Director and the DON's personal cellular phones. The DON responded and directed the PT Director to notify the WNM on staff and educate the resident on how to file a grievance. The PT Director notified the WNM of the resident's allegation.The PT Director was unwilling to provide the documentation of correspondence with the DON of the reporting of the allegation due to its location being on a personal cell phone device. On 03/11/2026 at 2:44 PM, the Resident Care Manager (RCM) defined physical abuse as kicking, hitting, pulling, and providing care in a rough manner. The RCM verbalized the PT Director notified the RCM of the physical abuse allegation on 03/11/2026 and the RCM had been previously unaware. The RCM indicated the CNA providing care for Resident #24 on 03/08/2026 was still working in the facility and was providing care to residents on 03/11/2026. The RCM was unable to review the allegations with the CNA.On 03/11/2026 at 2:57 PM, the CNA verbalized on the morning of 03/08/2026, the CNA entered Resident #24's room to provide care and the resident refused. After assisting three other residents the CNA noticed Resident #24's call light was on. The resident was upset with the CNA, and the CNA notified the WNM. The CNA requested to be removed from the resident's care but continued to provide care to the roommate. The CNA was not aware of any allegation of treating the resident roughly until the afternoon of 03/11/2026.On 03/11/2026 at 3:31 PM, the DON verbalized the DON had been notified of the allegation by the PT Director on 03/08/2026 at 12:08 PM and requested the WNM to obtain a statement from the resident. The DON verbalized the WNM had informed the DON the resident had alleged the CNA providing care to Resident #24 moved too quickly when transferring the resident and the resident did not believe the CNA understood proper care for a fractured hip. The DON verbalized the only statement collected was a verbal statement from the WNM. The DON explained having difficulty locating the verbal statement as the DON preferred to document on the DON's personal laptop. Upon retrieval of the WNM's statement, the DON confirmed the statement was not signed or dated by the WNM. The DON confirmed lack of notification to the resident's family, or the required State agencies.On 03/12/2026 at 8:51 AM, the WNM defined abuse as causing harm to an individual through physical, verbal, mental, or sexual abuse. The WNM gave the examples of name calling, being too rough, behaving aggressively, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	or anything causing a resident to feel unsafe. The WNM stated Resident #24 had a fracture in the resident's left femur and required assistance with transfers. The WNM conducted a full conversation with the resident, and the resident had felt the CNA was rough and transferred the resident too quickly. The CNA was removed from the resident's care but was allowed to continue to care for the resident's roommate. The WNM verbalized the CNA should have been removed from the resident's area. The WNM verbalized an allegation of physical abuse constituted temporary suspension of the alleged perpetrator until the conclusion of the investigation. The WNM verbalized the WNM should have included the Abuse Coordinator in the investigation, but it had not been completed. The WNM stated statements should have been collected from all parties involved, but this had not been completed.On 03/12/2026 at 2:49 PM, the Abuse Coordinator/Administrator verbalized when the Abuse Coordinator was not available the DON acted as the designee. When an allegation of abuse was reported the suspected staff member would be suspended immediately until the investigation was concluded. Written statements would be collected from all parties involved. The Administrator verbalized, If an allegation appears to be unfounded, I am not sure a preliminary investigation needs to be provided or recorded.A facility policy titled, Resident Rights, revised December 2016, documented employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence, be treated with respect, kindness, and dignity. be free from abuse, neglect, misappropriation of property, and exploitation. A facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation, Prevention Program, revised April 2021, documented residents had the right to be free from abuse, neglect, misappropriation, of resident property and exploitation. This included but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse. The facility would investigate and report any allegations within the timeframe required by federal requirements.A facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation, Reporting and Investigating, revised April 2021, documented all reports of resident abuse, neglect, exploitation are reported to local, state, and federal agencies as required by current regulations and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Investigating Allegations: All allegations are thoroughly investigated. The Administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. The individual conducting the investigation must at minimum: review documentation and evidence, review resident medical record to determine cognitive and medical status, observe alleged victim, interview persons reporting the incident, interview any witnesses, interview staff members who had contact with resident during incident, interview the resident roommate, review all events leading up to the incident, and document the investigation completely and thoroughly. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. Cross reference with F609, and F842.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident was provided with written notice of the facility bed-hold policy when 1 of 3 residents sampled for closed records (Resident #78) was transferred to a hospital. This deficient practice had the potential to result in an unsafe discharge and prevent the resident from being informed of the resident's rights related to returning to the facility.Findings include:Resident #78 Resident #78 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of idiopathic chronic gout, multiple sites, without tophus. A physician's progress note dated 02/18/2026 at 12:00 AM, documented Resident #78 was seen in bed and very confused. A smell of strong urine was present. A urinalysis was ordered and medications were adjusted due to concern for worsening confusion. The provider would send the resident to acute for concern of worsening infection.Resident #78's Discharge Minimum Data Set 3.0 (MDS) assessment dated [DATE], section A0310 (Identification Information - Optional Resident Items) documented discharge to a short-term general hospital with a discharge date of 02/18/2026.Resident #78's clinical record lacked documented evidence of a bed-hold notification.On 03/12/2026 at 11:01 AM, the Resident Care Manager Registered Nurse (RCM) verbalized administration would be responsible for completed documentation related to a resident's discharge. The RCM was familiar with Resident #78, however could not recall the specifics of the resident's discharge. On 03/12/2026 at 1:40 PM, the Director of Nursing (DON) explained the direct care nurse present during transfer and the RCM were responsible to educate the resident on the facility's bed-hold policy. This education would include written documentation of bed-hold notification. Bed-hold notifications would be scanned into the resident's electronic record or stored in the medical records office. The DON recalled Resident #78 was sent to the hospital on [DATE] due to altered mental status. The DON believed the facility expected Resident #78 to return to the facility after being stabilized; however, the resident did not return and was discharged from the facility. The DON verbalized the DON was unable to locate a bed-hold notification within Resident #78's clinical record or in the medical records office. The DON explained the facility previously collected verbal consents which may explain the lack of bed-hold notification documentation. The DON explained it was important to provide bed-hold notifications to ensure transferring residents were aware of the right to return to the facility. The facility policy titled Bed Hold Policy, undated, documented a bed-hold would be initiated when a resident was transferred to an acute hospital for medical purposes. The bed hold policy differed depending on the source of pay.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise the comprehensive personˆcentered care plan to address changes in the resident's condition after experiencing two falls for 1 of 18 sampled residents (Resident #34). This deficient practice had the potential to result in unmet care needs, continued fall risk, and preventable injury.Findings included:Resident #34Resident #34 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including muscle weakness and difficulty in walking.Resident #34's initial care plan for falls dated 12/19/2025 identified the resident as being at risk for falls and included baseline fallˆprevention interventions.Resident #34's clinical record showed the resident sustained two falls in the facility on 12/24/2025 and 01/08/2026. These falls represented a change in the residents' condition requiring reassessment and revision of the care plan.Resident #34's clinical record lacked documented evidence the care plan was revised following either fall. No new fallˆprevention interventions were added, and no modifications were made to existing interventions to address the residents' repeated falls. The care plan remained unchanged from the 12/19/2025 version.On 03/11/2026 at 10:12 AM, a Licensed Practical Nurse (LPN) explained the care plan would be reviewed and updated following a resident's fall by the Resident Care Manager (RCM). The LPN confirmed no revisions were completed to Resident #34's care plan following the resident's falls.On 03/11/2026 at 10:17 AM, the RCM Registered Nurse explained care plans were initiated and updated as needed. The RCM verbalized care plans would be updated post fall to include new fallˆprevention interventions, and mobility and transfers would be evaluated by physical therapy. The RCM confirmed Resident #34's care plan was initiated in December and was not updated after the resident sustained falls in the facility.On 03/11/2026 at 2:34 PM, the Director of Nursing (DON) explained when a resident experienced falls, an assessment was completed to determine the root cause and update the care plan with new interventions. The DON verbalized care plans were updated to ensure resident safety and to identify interventions to meet the resident's needs. The DON confirmed Resident #34's care plan had not been updated to include the facility falls, revised interventions, or a documented rootˆcause assessment.The facility policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, documented care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and the relevant clinical decision making. When possible, interventions address the underlying sources of the problem areas, not just symptoms or triggers. Assessments of the residents were ongoing, and care plans were revised as information about the residents and the residents' conditions changed. Cross reference with F689

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice when 1 of 18 sampled residents (Resident #55) was not assisted with transportation to an orthopedics appointment outside the facility. This deficient practice had the potential to result in a delay in required services and hindered wound recovery.Findings include:Resident #55 Resident #55 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acquired absence of right leg below knee and encounter for orthopedic aftercare following surgical amputation. A provider consultation form dated 02/12/2026, documented the resident was seen for orthopedic services to include range of motion knee extension and splint care. A follow-up appointment was made for 02/26/2026 at 3:00 PM. A provider consultation form dated 02/19/2026, documented the resident was seen for orthopedic services to include suture removal and dressing change. Follow-up was recommended for one week. A follow-up appointment was kept for 02/26/2026. The appointment calendar for 02/26/2026 documented Resident #55 had an orthopedics appointment at 3:00 PM, no transport. On 03/09/2026 at 4:07 PM, Resident #55 verbalized the facility lacked appropriate communication with residents regarding transportation to outside services. Resident #55 recalled approximately two weeks prior; the resident had an orthopedics appointment to receive care after a recent surgery. The resident recalled on the day of the appointment, the resident approached the nursing station and asked about the plan for transportation. A Registered Nurse (RN) referred to a communication slip indicating family would assist with transportation. The resident verbalized the resident did not have family available to assist with transportation. The resident explained the resident missed the orthopedics appointment because the facility did not have accurate information. On 03/12/2026 at 9:04 AM, the RN explained staff were made aware of resident appointments through the appointment calendar. Transportation would discuss with the resident the transportation plan and would populate the appointment calendar with the outside entity, the time and the transportation plan. Night shift nurses were responsible for preparing the transportation packet to include a face sheet, medication summary, provider notes, and a blank provider consultation form. The RN explained Resident #55 recently had surgery and was scheduled for follow-up orthopedic appointments to monitor the resident's amputation site. The RN recalled approximately two weeks prior; there was miscommunication between the resident and the facility regarding transportation. The RN was present on the day of the appointment but did and believed the appointment calendar and provider consultation form indicated family would assist the resident to the orthopedics appointment. The RN had not spoken with the resident regarding the transportation plan. At around noon on the day of the appointment, the RN asked the resident why the resident was still present in the facility and the resident explained the resident was under the impression the facility would be assisting with transportation. The resident informed the RN the resident did not have family to assist with transportation. The resident missed the appointment, Transportation was informed, and a new appointment was scheduled for the following week. On 03/12/2026 at 9:15 AM, the Transportation Certified Nursing Assistant (CNA) verbalized either the direct care nurse present on the day of transport, or the Transportation CNA would collaborate with the resident prior to a scheduled appointment to determine what type of transportation assistance was required. There would be no documentation of the discussion with the resident. The Transportation CNA would then update the appointment calendar to include the date, time and location of the appointment along with the transportation type. The facility had access to two vehicles for transportation to outside services. If both vehicles were unavailable, the facility would organize external transportation. The Transportation CNA explained Resident #55 received weekly orthopedic services because of the need for extensive wound care related to a recent surgery. The Transportation CNA explained on 02/26/2026, the appointment calendar documented Resident #55 (continued on next page)

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Sierra Basin Post Acute	1001 N. Mountain Street Carson City, NV 89703

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was to receive family transport to an orthopedic appointment; however, the resident required transportation assistance provided by the facility. The resident missed the appointment due to a lack of transportation assistance, and the appointment was rescheduled for 03/05/2026. The Transportation CNA could not recall who discussed the transportation plan with the resident and when the calendar was updated. The facility policy, titled Transportation, Social Services, revised 12/2008, documented residents would be assisted as needed to obtain transportation.

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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, and record review, the facility failed to ensure supervision and assistive devices were provided to prevent accidents by failing to revise the comprehensive personˆcentered care plan after the resident experienced two falls for 1 of 18 sampled residents (Resident #34). This deficient practice had the potential to result in unmet care needs, continued fall risk, and preventable injury.Findings included:Resident #34Resident #34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness and difficulty in walking.On 03/09/2026 at 11:12 AM, Resident #34 verbalized having two falls while in the facility. The first fall happened when attempting to transfer to the wheelchair and the wheelchair breaks were not set. The second fall happened when attempting to use the toilet. Resident #34 explained having been in pain after the second fall and required x-rays for the hip and hand.Resident #34's clinical record showed the resident sustained two falls in the facility on 12/24/2025 and 01/08/2026. These falls represented a change in the residents' condition requiring reassessment and revision of the care plan.A progress note dated 12/29/2025 documented Resident #34 had a fall and to begin neuro checks.A post fall review was completed on 12/29/2025; however, the resident's care plan was not updated to reflect updated interventions.A progress note dated 01/13/2026 documented Resident #34 had fallen in the bathroom in the therapy gym. The resident explained was transferring from the wheelchair to the toilet. A nurse assessed the resident and assisted the resident back in the wheelchair.A post fall review was completed on 01/14/2026; however, the resident's care plan was not updated to reflect updated interventions.The resident's initial care plan for falls dated 12/19/2025 identified the resident as being at risk for falls and included baseline fallˆprevention interventions.Resident #34's clinical record lacked documented evidence the care plan was revised following either fall. No new fallˆprevention interventions were added, and no modifications were made to existing interventions to address the residents' repeated falls. The care plan remained unchanged from the 12/19/2025 version.On 03/11/2026 at 10:12 AM, a Licensed Practical Nurse (LPN) explained the care plan would be reviewed and updated following a resident fall by the Resident Care Manager (RCM). The LPN confirmed no revisions were completed to Resident #34's care plan following the resident's falls.On 03/11/2026 at 10:17 AM, the RCM Registered Nurse explained care plans were initiated and updated as needed. The RCM stated care plans would be updated after a fall to include new fallˆprevention interventions, and mobility and transfers would be evaluated by physical therapy. The RCM confirmed Resident #34's care plan was initiated in December and was not updated after the resident sustained falls in the facility.On 03/11/2026 at 2:34 PM, the Director of Nursing (DON) explained when a resident experienced falls, an assessment was completed to determine the root cause and update the care plan with new interventions. The DON verbalized care plans were updated to ensure resident safety and identify interventions to meet the resident's needs. The DON confirmed Resident #34's care plan had not been updated to include the facility falls, revised interventions, or a documented rootˆcause assessment.The facility policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, documented care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and the relevant clinical decision making. When possible, interventions address the underlying sources of the problem areas, not just symptoms or triggers. Assessments of the residents were ongoing, and care plans were revised as information about the residents and the residents' conditions changed.The facility policy titled Falls and Fall Risk, Managing, revised March 2018, documented based on previous evaluation and current data, the stall would identify intervention related the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The staff would (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Cross reference with F657

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to ensure the treatment/wound cart containing resident medications was secured. This deficient practice had the potential to result in unauthorized access to medications.Findings include:On 03/12/2026 at 11:36 AM, a treatment/wound cart was observed unlocked in the resident care area. There was no nursing staff present in the area at the time of the observation. The following medications were noted inside drawers one and two of the cart: one tube of lidocaine cream one tube of triamcinolone (TAC) cream three bottles of nystatin powderOn 03/12/2026 at 11:40 AM, the Resident Care Manager (RCM) Registered Nurse confirmed the treatment cart had been left unlocked and explained it should not be left unlocked. The RCM Registered Nurse verbalized it was important to keep the cart locked to keep residents, and visitors from getting in the cart and to keep everyone safe.On 03/12/2026 at 1:59 PM, the Director of Nursing verbalized the expectation was for staff to ensure the treatment cart was locked before walking away.The facility policy titled Storage of Medications, undated, documented drugs and biologicals used in the facility were stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications had access to locked medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident's medical record was complete for 1 of 18 sampled residents (Resident #24). The deficient practice had the potential for staff to be unaware of resident needs resulting in further harm.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], with diagnoses including fracture of left femur, fracture around internal prosthetic left hip joint, and chronic obstructive pulmonary disease.On 03/09/2026 at 12:00 PM, Resident #24 verbalized a Certified Nursing Assistant (CNA) had handled the resident roughly and the resident was concerned the CNA would cause further injury to an existing fracture in the resident's hip. Resident #24 had requested the Physical Therapy Assistant (PTA) remove the CNA from the resident's care due to the CNA handling the resident roughly when providing care. The resident verbalized feeling unsafe as the CNA continued to enter the resident's room to provide care to the resident's roommate.A Physical Therapy Treatment Encounter Note dated 03/08/2026 at 06:26 PM, documented Resident #24 requested to speak with a supervisor and verbalized a CNA had been rough with the resident. A Registered Nurse (RN)/Weekend Nurse Manager (WNM) was notified.On 03/11/2026 at 1:33 PM, the Physical Therapy Director (PT Director) defined abuse as being physically or verbally harmful and withholding care needed to meet basic human rights. Any willful and harmful emotional, physical, or sexual act would constitute abuse. The PT Director confirmed treating a resident roughly could be considered abuse. The PT Director recalled the PT Director had been notified on 03/08/2026, Resident #24 had informed the PTA a CNA was rough with the resident. The PT Director notified the Director of Nursing (DON) of the incident via text message between the PT Director and the DON's personal cellular phones. The DON responded and directed the PT Director to notify the WNM on staff and educate the resident on how to file a grievance. The PT Director notified the WNM of the resident's allegation.The PT Director was unwilling to provide the documentation of correspondence with the DON due to the communication was maintained on the PT Director's personal cell phone and had not been documented in the resident record or maintained in facility files as required. The facility was unable to produce documentation verifying when the allegation was reported to the DON, the content of the communication, or any actions taken in response. The lack of available documentation prevented the facility to ensure the required records were complete, accurate, and readily accessible.On 03/11/2026 at 2:44 PM, the Resident Care Manager (RCM) defined physical abuse as kicking, hitting, pulling, and providing care in a rough manner. The RCM verbalized the PT Director notified the RCM of the physical abuse allegation on 03/11/2026 and the RCM had been previously unaware. The RCM indicated the CNA providing care for Resident #24 on 03/08/2026 was still working in the facility and was providing care to residents on 03/11/2026. The RCM was unable to review the allegations with the CNA.On 03/11/2026 at 2:57 PM, the CNA verbalized on the morning of 03/08/2026, the CNA entered Resident #24's room to provide care and the resident refused. After assisting three other residents the CNA noticed Resident #24's call light was on. The resident was upset with the CNA, and the CNA notified the WNM. The CNA requested to be removed from the resident's care but continued to provide care to the roommate. The CNA was not aware of any allegation of treating the resident roughly until the afternoon of 03/11/2026.On 03/11/2026 at 3:31 PM, the DON verbalized the DON had been notified of the allegation by the PT Director on 03/08/2026 at 12:08 PM and requested the WNM to obtain a statement from the resident. The DON verbalized the WNM had informed the DON the resident had alleged the CNA providing care to Resident #24 moved too quickly when transferring the resident and the resident did not believe the CNA understood proper care for a fractured hip. The DON verbalized the only statement collected was a verbal statement from the WNM. The DON explained having difficulty locating the verbal statement as the DON preferred to document on the DON's personal (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	laptop. Upon retrieval of the WNM's statement, the DON confirmed the statement was not signed or dated by the WNM. The DON confirmed lack of notification to the resident's family, or the required State agencies.On 03/12/2026 at 8:51 AM, the WNM defined abuse as causing harm to an individual through physical, verbal, mental, or sexual abuse. The WNM gave the examples of name calling, being too rough, behaving aggressively, or anything causing a resident to feel unsafe. The WNM stated Resident #24 had a fracture in the resident's left femur and required assistance with transfers. The WNM conducted a full conversation with the resident, and the resident had felt the CNA was rough and transferred the resident too quickly. The CNA was removed from the resident's care but was allowed to continue to care for the resident's roommate. The WNM verbalized the CNA should have been removed from the resident's area. The WNM verbalized an allegation of physical abuse constituted temporary suspension of the alleged perpetrator until the conclusion of the investigation. The WNM verbalized the WNM should have included the Abuse Coordinator in the investigation but had not been completed. The WNM stated the WNM should have collected statements from all parties involved but had not been completed.On 03/12/2026 at 2:49 PM, the Abuse Coordinator/Administrator verbalized when the Abuse Coordinator was not available the DON acted as the designee. When an allegation of abuse was reported the suspected staff member would be suspended immediately until the investigation was concluded. Written statements would be collected from all parties involved. The Administrator verbalized, If an allegation appears to be unfounded, I am not sure a preliminary investigation needs to be provided or recorded.A facility policy titled, Resident Rights, revised December 2016, documented employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence, be treated with respect, kindness, and dignity. be free from abuse, neglect, misappropriation of property, and exploitation. The facility was unable to provide a completed abuse investigation, abuse report, and updated administration and clinical resident record reflecting any changes made to the resident's care. A facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation, Prevention Program, revised April 2021, documented residents had the right to be free from abuse, neglect, misappropriation, of resident property and exploitation. This included but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse. The facility would investigate and report any allegations within the timeframe required by federal requirements.A facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation, Reporting and Investigating, revised April 2021, documented all reports of resident abuse, neglect, exploitation are reported to local, state, and federal agencies as required by current regulations and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Investigating Allegations: All allegations are thoroughly investigated. The Administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. The individual conducting the investigation must at minimum: review documentation and evidence, review resident medical record to determine cognitive and medical status, observe alleged victim, interview persons reporting the incident, interview any witnesses, interview staff members who had contact with resident during incident, interview the resident roommate, review all events leading up to the incident, and document the investigation completely and thoroughly.Cross reference with F609, and F842.

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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. Based on observation, interview, and document review, the facility failed to ensure a staff member performed hand hygiene when assisting residents in the dining room for 4 of 4 observed opportunities to perform hand hygiene. This deficient practice had the potential to result in the spread of bacteria and viruses, including multi drug resistant organisms, to the residents in the facility.Findings include:On 03/09/2026 at 12:14 PM, a staff member was assisting residents in the dining room. The staff member performed the following activities without performing hand hygiene:delivered coffee to a resident.touched the back of a resident's chair.touched the table in front of a resident and then touched the resident's chair.assisted a resident with opening a container of salad dressing and then poured the dressing over the resident's salad.The staff member confirmed the staff member had not performed hand hygiene in between touching residents or before assisting a resident with the resident's salad dressing. The staff member verbalized the staff member should have washed their hands or performed hand hygiene in between contact with residents.On 03/12/2026 at 1:33 PM, the Infection Preventionist verbalized staff should have performed hand hygiene or washed their hands in between touching residents or anytime a staff member touched a surface.The facility policy titled Handwashing/Hand Hygiene, revised 08/2019, documented the facility considered hand hygiene the primary means to prevent the spread of infections. Hand hygiene would be performed before and after direct contact with residents, after contact with objects in the immediate vicinity of the residents, and before and after assisting a resident with meals.