STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. Building B. Wing	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Skilled Nursing and Rehabilitation Center	3101 Plumas St Reno, NV 89509

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 0600 Level of Harm - 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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a bed fast resident with limited mobility received necessary care during a power outage resulting in actual harm when the resident developed a deep tissue injury for 1 of 10 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paraplegia, unspecified, need for assistance with personal care, moderate protein-calorie malnutrition. A facility reported incident, dated 01/04/23, documented on 01/02/23, Resident #3 was found by the wound care provider and a nurse to have a new wound to the resident's sacral area and the resident's air mattress was deflated. On 01/18/23 at 9:15 AM, the Administrator verbalized the facility had a power outage starting on 12/31/22 between 3:00 PM and 4:00 PM, and the power was not restored until 01/03/23. The Administrator verbalized the plug for the air mattress had not been plugged into an emergency power outlet during the power outage. The Administrator confirmed the plug for the resident's air mattress was not plugged into an emergency outlet receiving power from the generator until after the resident's wound was discovered on 01/02/23. A Wound Care Specialist Nurse Practitioner note, dated 12/26/22, documented the resident had one wound to the resident's left great toe. A Wound Care Specialist Nurse Practitioner note, dated 01/02/23, documented the resident had developed a second wound. The new wound was a pressure sacral coccyx deep tissue injury measuring eight centimeters (cm) by 11 cm with moderate serosanguineous drainage. On 01/18/23 at 11:41 AM, the Wound Care Registered Nurse (RN) verbalized the deep tissue injury to Resident #3's sacral area was a new skin condition discovered after the power outage as a result of the deflated mattress. (continued on next page)

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 01/18/23 at 11:52 AM, the Administrator and the Director of Nursing (DON) verbalized the generator had been operational during the power outage, but the resident's air mattress was not plugged in to an emergency outlet with power supplied by the generator. On 01/18/23 at 12:21 PM, Resident #3 verbalized the staff did not check the resident's air mattress regularly. On 01/18/23 at 12:27 PM, an Licensed Practical Nurse was unable to find an emergency outlet in the room of Resident #3 and did not know what outlet the resident's air mattress would be plugged into to ensure the mattress remained inflated in the event of a power outage. On 01/18/23 at 12:39 PM, the Administrator verbalized Resident #3's room did not have an emergency outlet and the facility would have to run an extension cord from the resident's room into the hallway to the nearest available emergency outlet. On 01/18/23 at 3:23 PM, the DON verbalized the DON was the abuse coordinator for the facility. The DON verbalized any management in the facility during the power outage would have been responsible for checking to ensure medical equipment used by residents was plugged into an emergency power outlet. The DON verbalized the facility staff did not think of the resident's air mattress during the power outage. The DON verbalized the responsibility of checking the resident's air mattress was operating correctly was the responsibility of the bedside nurses, Certified Nurse's Assistants, and any staff entering the resident's room. The air mattress check would include pushing on the air mattress to ensure it was inflated and checking the settings. The DON verbalized the facility determined it was not neglect when an ordered treatment and checking the air mattress settings every shift was not completed for three days, resulting in a deep tissue injury. A Physician's Order dated 02/09/22, documented low air loss mattress on bed, confirm inflation every shift. The December 2022 and January 2023 TAR documented low air loss mattress on bed, confirm inflation every shift for wound care/pressure relief/redistribution. There was no documentation for the air mattress check for all of December 2022 through 01/10/23. The facility policy titled Emergency Procedure - Utility Outage, revised 08/2018, documented resident would remain safe and comfortable during a temporary loss of power. Staff would monitor residents to ensure they were safe and check resident-used medical equipment. The facility policy titled Recognizing Signs and Symptoms of Abuse/Neglect, revised 01/2011, documented the facility would not condone any form of resident abuse or neglect. Neglect was defined as failure to provide goods and services as necessary to avoid physical harm. Signs of actual physical neglect included inadequate provision of care. FRI #NV00067711

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review the facility failed to ensure a resident received the appropriate care to not develop a deep tissue injury (DTI) while in the facility resulting in actual harm for 1 of 10 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paraplegia, unspecified, need for assistance with personal care, moderate protein-calorie malnutrition. A facility reported incident, dated 01/04/23, documented on 01/02/23, Resident #3 was found by the wound care provider and a nurse to have a new wound to the resident's sacral area and the resident's air mattress was deflated. On 01/18/23 at 9:15 AM, the Administrator verbalized the facility had a power outage starting on 12/31/22 between 3:00 PM and 4:00 PM, and the power was not restored until 01/03/23. The Administrator verbalized the plug for the air mattress had not been plugged into an emergency power outlet during the power outage. The Administrator confirmed the plug for the resident's air mattress was not plugged into an emergency outlet receiving power from the generator until after the resident's wound was discovered on 01/02/23. A Wound Care Specialist Nurse Practitioner note, dated 12/26/22, documented the resident had one wound to the resident's left great toe. A Wound Care Specialist Nurse Practitioner note, dated 01/02/23, documented the resident had developed a second wound. The new wound was a pressure sacral coccyx deep tissue injury measuring eight centimeters (cm) by 11 cm with moderate serosanguineous drainage. A Nursing Note dated 01/02/23, documented the writer did a skin sweep on the resident and discovered a sacral coccyx area had a pressure injury measuring eight cm by ll cm. The area was purple and had moderate serosanguinous drainage. On 01/18/23 at 11:41 AM, the Wound Care Registered Nurse (RN) verbalized the deep tissue injury to Resident #3's sacral area was a new skin condition discovered after the power outage. On 01/18/23 at 11:52 AM, the Administrator and the Director of Nursing (DON) verbalized the generator had been operational during the power outage, but the resident's air mattress was not plugged in to an emergency outlet with power supplied by the generator. On 01/18/23 at 12:21 PM, Resident #3 verbalized the staff did not check the resident's air mattress regularly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/18/23 at 3:23 PM, the DON verbalized any management in the facility during the power outage would have been responsible for checking to ensure medical equipment used by residents was plugged into an emergency power outlet. The DON verbalized the facility staff did not think of the resident's air mattress during the power outage. The DON verbalized the responsibility of checking the resident's air mattress was operating correctly was the responsibility of the bedside nurses, Certified Nurse's Assistants, and any staff entering the resident's room. The air mattress check would include pushing on the air mattress to ensure it was inflated and checking the settings. A Physician's Order dated 02/09/22, documented low air loss mattress on bed, confirm inflation every shift. The December 2022 and January 2023 Treatment Administration Record (TAR) documented low air loss mattress on bed, confirm inflation every shift for wound care/pressure relief/redistribution. There was no documentation for the treatment for all of December 2022 through 01/10/23. The facility policy titled Emergency Procedure - Utility Outage, revised 08/2018, documented resident would remain safe and comfortable during a temporary loss of power. Staff would monitor residents to ensure they were safe and check resident-used medical equipment. The facility policy titled Pressure Ulcer Prevention and Management, undated, documented caregivers would communicate skin breakdown risk and a skin check would be completed daily. Staff would be trained on the prevention of pressure ulcers including pressure reduction and relief measures. FRI #NV00067711