Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10231	A. BUILDING _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO RED ROCK	7540 SMOKE RANCH ROAD, LAS VEGAS, NEVADA ,89128

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and infection control survey conducted at your facility on 02/14/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 72 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was 28. Ten resident files and nine employee files were reviewed. The facility received a grade of D. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the exterior of the facility was well maintained. Findings include: On 02/14/23 in the morning, several piles of dog feces were observed in both outside courtyard areas. There were approximately four piles located in the south courtyard area and six piles located in the north courtyard area. On 02/14/23 in the morning, the Director of Plant Operations confirmed the presence of the feces in both courtyards. The Director of Plant Operations explained there was a resident who owned two dogs and there were two "facility dogs" who freely roamed the facility. The Director indicated all four dogs used the courtyard areas for biological waste elimination but none of the staff were designated to check the courtyard areas and/or clean up after the dogs. The Director verbalized there would be two additional dogs coming to live at the facility shortly and acknowledged this as a growing problem. On 02/14/23 in the morning, the Administrator acknowledged this as an unattended sanitary problem that needed to be resolved as soon as possible. Severity: 2 Scope: 3	0178	Tag – 0255 On 2/23/23, an in-service (attachment # 0255-1) was done by the administrator at our all-staff meeting, which included training on safe food storage, monitoring expiration dates and labeling, and proper storage of food and personal items The Culinary Director, Senior Engagement Director, Nexus Program Director, and Administrator will monitor for compliance.	02/23/2023

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0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 02/14/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the kitchen walk-in cooler and reach-in refrigerator, two bottles of lemon juice were expired 02/06/23. In one dining room refrigerator, two yogurt cups were expired 01/31/23. In the activity area, hot chocolate mix was expired 11/2022. b. In the walk-in cooler, raw shrimp was stored over cantaloupe. 2. Major Violations: a. In the activity area, ware was washed in the hand sink and stored on the side of the hand sink to dry. Severity: 2 Scope: 3	0255	Tag – 0255 On 2/23/23, an in-service (attachment # 0255-1) was done by the administrator at our all-staff meeting, which included training on safe food storage, monitoring expiration dates and labeling, and proper storage of food and personal items. On 4-3-23, the Nexus Program Director did another follow-up in-service to reinforce the proper washing of all dishes to be in the dining room commercial dishwashers or the main kitchen dishwasher. (attachment 0255-2) The Culinary Director, Senior Engagement Director, Nexus Program Director, and Administrator will monitor for compliance.	02/23/2023
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to	0870	Tag – 0870 Silverado has an ongoing contract with Omnicare Pharmacy that includes semi-annual medication reviews. The most recent medication review occurred on March 1, 2023, and each review is scheduled to occur every six months moving forward. (Attachment 0870-1 & 0870-2). (Attachment 0870-3 – need contract). The Director of Health Services and Administrator will monitor for compliance.	03/01/2023

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	paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure the medication regimen was reviewed every six months by a pharmacist, physician, or registered nurse for 2 of 10 sampled residents (Resident #7 and Resident #8). Findings include: Resident #7 (R7) R7 was admitted to the facility on 03/24/2022 with diagnoses including Alzheimer's, insomnia, major depressive disorder, and coronary artery disease . There was no documented evidence the medication regimen was reviewed by a physician, pharmacist or registered nurse for R7 since admission on 03/24/2022. Resident #8 (R8) R8 was admitted to the facility on 03/17/2022 with diagnoses including Dementia with Behavioral Disturbances, Hypertension, and Non-Pressure Chronic Ulcers of the Lower Leg. There was no documented evidence the medication regimen was reviewed by a physician, pharmacist or registered nurse for R8 since admission on 03/17/2022. On 02/14/23 at 12:30 PM, the Administrator verified there was no system in place for the medication regimens to be reviewed by a pharmacist, physician, or registered nurse at least every six months. Severity: 2 Scope: 1			

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0876 SS= F	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 10 of 10 sampled residents had a signed an Ultimate User Agreement, granting permission to the facility to assist in the administration of the residents' medication. The resident files documented the facility was administering all ten resident's medications. Resident #1 was admitted on 07/08/22, Resident #2 was admitted on 11/03/22, Resident #3 was admitted on 08/29/22, Resident #4 was admitted on 04/23/22, Resident #5 was admitted on 10/25/22, Resident #6 was admitted on 08/01/22, Resident #7 was admitted on 03/24/22, Resident #8 was admitted on 03/17/22, Resident #9 was admitted on 01/18/23, and Resident #10 was admitted on 09/27/22. On 02/14/22 in the afternoon, the Administrator acknowledged the residents were missing a signed Ultimate User Agreement. Severity: 2 Scope: 3	0876	ag – 0876 Due to being an all-memory care community and for the safety of our residents, we do not offer the option for residents to administer their own medications. We have created an ultimate user agreement using the specific format that the surveyor recommended (attachment 0876-1). We began including the above attachment in our move-in packet on February 25, 2023, and have sent to all responsible parties requesting that they sign and return by 4/15/23. Any families that visit or attend a care conference prior to April 15, 2023, will be presented with this form and requested to sign. The Director of Health Services and Administrator will monitor for compliance.	02/25/2023

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure all exit doors were equipped with audible alarms that activated when the doors were opened. Findings include: On 02/14/23 in the morning, there was no audible alarm installed on the front entrance/exit doors. The doors were locked and were opened using a numerical code. On 02/14/23 in the morning, there were no audible alarms installed on the doors leading out to the courtyard areas. On 02/14/23 in the morning, there were no audible alarms installed on any exit doors leading to outside the facility. On 02/14/23 in the morning, the Administrator and the Director of Plant Operations verbalized they were unaware all exit doors, including the doors leading out to the courtyard areas, needed to be audibly alarmed. They indicated all exit doors leading to outside the facility were magnetically locked and could only be opened using a numerical code or when the fire alarm was activated. The Administrator and Director of Plant Operations were under the impression this satisfied the regulation requirement. Severity: 2 Scope: 3	0991	Tag – 0991 Alarms have been on all exit doors since licensure; however, they sound directly into all staff radios/earpieces. Standard audible alarms that sound to anyone within earshot were installed on 3-3 -23 on all exit doors (rear delivery exit, kitchen exit, both dining room exits, and both front lobby doors) (Attachment 0991-1) The Director of Plant Operations and Administrator will monitor for compliance.	03/03/202 3

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0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp objects were not accessible to residents. Findings include: On 02/14/23 at 9:45 AM, scissors were accessible to residents in the following areas: -The activity area near the front lobby located in an unlocked cupboard. -Two administrative offices were open and unoccupied. On 01/14/2023 at 10:20 AM, the social worker acknowledged the scissors were unsecured and accessible to residents. Severity: 2 Scope: 3	0994	Tag – 0994 As of 2-14-23, all engagement sharp objects have been placed in locked storage closets. We have scheduled additional locks to be installed the week of April 10, 2023, to our great room drawers and cabinets to allow for extra storage space. All great room / lobby offices are locked when not occupied if they contain any items that could be of danger to a resident and that are not secured in a locked compartment. All Leadership team members will be responsible for the securing of their offices when unoccupied. The Director of Health Services and Administrator will monitor for compliance.	02/14/2023

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 02/14/2023 at 9:45 AM, there were four bottles of lotion located in an unlocked cupboard in Dining Room A. On 02/14/2023 at 11:35 AM, there was one bottle of lotion and one bottle of Proxy spray cleaner located in an unlocked cupboard in Dining Room B. On 02/14/2023 at 12:15 PM, there was six bottles of liquid glue located in a bin labeled "glue" in a unlocked cupboard in the activity area near the front lobby. On 02/14/2023 at 12:15 PM, two staff members acknowledged the lotions and glue were not secured and accessible to residents. Severity: 2 Scope: 3	0999	Tag – 0999 Staff were in-serviced by Administrator (attachment 0255-1) in the all-staff meeting on 3-23-23 regarding proper storage of personal items, lotions, and cleaning supplies, glues, etc. (all items that could be toxic or harmful to residents). All items were removed and properly stored the day of the survey when addressed and have been and will continue to be checked daily going forward. The Plant Operations Director, Nexus Program Director, Director of Resident Engagement, Director of Health Services, and Administrator will monitor for compliance.	03/23/2023

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1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on interview and record review, the facility failed to: submit an application for a cultural competency training program in compliance with R016-20; and ensure 9 of 9 employees were in compliance with Nevada Revised Statues (NRS) 449.103, regarding annual cultural competency training. There was no documented Cultural Competency training for Employees #1, #2, #3, #4, #5, #6, #7, #8 and #9. The Administrator confirmed Cultural Competency training was not completed for any employees and the facility did not have an approved Cultural Competency training program in place. Severity: 2 Scope: 3	1540	Tag – 1540 We resubmitted curriculum on March 29, 2023, to be able to present the cultural competency class in-house to Silverado associates (attachment 1540-1 & 1540-10). Prior to obtaining that approval, we are putting all associates through the approved third-party training with ASL Training. They are being required to complete this training no later than 4-23-23. To date a total of 18 associates have completed, which includes all of the Leadership Team (attachments 1540-2 through 1540-9) The Administrator and Director of Health Services will monitor for compliance.	04/23/2023