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
	10418	A. BUILDING _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS CASTLE OF KINGS ROW	1875 KINGS ROW, RENO, NEVADA ,89503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 09/28/22. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for eight residential Facility for Group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was four. Four resident files and five employee files were reviewed. The facility received a grade of A. 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		

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0170 SS= F	Health And Sanitation-Safe Water & Sewage - NAC 449.209 Health and sanitation. (NRS 449.0302) 1. A residential facility must: (a) Have a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage. Inspector Comments: Based on measurement and interview, the facility failed to ensure bathroom water temperature was at a safe level. Findings include: On 09/28/22, water temperatures in two bathrooms were measured with a State issued thermometer. Below are the temperatures which measured greater than 100 degrees Fahrenheit (safe for bathing). On 09/28/22 at 10:06 AM, in the hallway bathroom, the sink water measured 133 degrees Fahrenheit. On 09/28/22 at 10:06 AM, the Caregiver confirmed the water temperature. On 09/28/22 at 10:09 AM, in the bathroom at the end of the hallway, the sink water measured 130 degrees Fahrenheit. On 09/28/22 at 10:09 AM, the Caregiver confirmed the water temperature. Note: Time and temperature relationship to third degree burn to occur: 155 degrees Fahrenheit 1 second 148 degrees Fahrenheit 2 seconds 140 degrees Fahrenheit 5 seconds 133 degrees Fahrenheit 15 seconds 127 degrees Fahrenheit 1 minute 124 degrees Fahrenheit 3 minute 120 degrees Fahrenheit 5 minutes 100 degrees Fahrenheit Safe for bathing Severity: 2 Scope: 3	0170	Tag#0170 The facility will continuously monitor the water temperature to make sure no resident will be burn and be harm. immediately after the survey the water heater was adjusted and lowered the temperature. The water heater will be service and calibrated to certified technician and authorized service center.	03/10/2023

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0178 SS= D	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 observations and interview, the facility failed to ensure a bathtub was maintained free of mold and the exterior premises were clean and maintained. Findings include: On 09/28/22 at 10:04 AM, a hall bathroom contained a bathtub with a large amount of mold. On 09/28/22 at 10:04 AM, the Caregiver verbalized staff had tried unsuccessfully to remove the mold and confirmed the mold needs to be removed. On 09/28/22 at 10:16 AM, a headboard/footboard and bed frame were stored outside against the house. On 09/28/22 at 10:16 AM, the Caregiver was unaware why the bed was stored in the yard. Severity: 2 Scope: 1	0178	Tag # 0178: The facility will ensure that the environmental sorroundings of the facility inside and out are well maintained and clean and functional. The mold in the bathtub has been scraped and clean with bleach and a new silicon was applied see attached picture. The hospital bed outside was pickup by the owner after the survey. We will make sure use the storage next time and not to leave it outside.	03/10/2023

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, interview and record review, the facility failed to store a resident's medication in the container (Resident #2). Findings include: Resident #2 Resident #2 was admitted on 06/05/22 with diagnoses to include failure to thrive, small cell lung cancer, and stage three chronic kidney disease. Resident #2's September 2022 Medication Administration Record (MAR) and physician's order dated 07/05/22, documented Symbicort 160-4.5 mcg/aero, inhale two puffs two times a day. Use spacer. Rinse mouth after each use. The medication was located in Resident #2's medication bin; however, was stored in a plastic zipper bag without identifying information and order information. On 09/28/22 at 10:53 AM, the Caregiver confirmed the Symbicort was Resident #2's and verbalized the medication lacked identifying and order information. Severity: 2 Scope: 1	0923	Tag no. 0923, The facility will ensure. that all medication will be kept on the original box with the physician's name, date name of medication and the resident name. Will also ensure that all medication will put on the right container to avoid confusion. Will also make sure that administering medication to be accurate and on time. Continuous medication training and double checking in order to avoid mistakes in medication management will be a must for all caregivers administering medications.(medtech)	03/10/2023