DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/06/2023**

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 and complaint investigation State Licensure survey conducted in your facility on 07/06/23. 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 five. The sample size was three. Five resident files and five employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Complaint #NV00067666 with five allegations could not be substantiated due to lack of evidence. Allegation #1: A caregiver hit a resident. Allegation #2: A caregiver threatened to harm a resident. Allegation #3: A caregiver cut the resident's hair and verbally insulted the resident. Allegation #4: A caregiver pushed a resident down. Allegation #5: A caregiver poured cereal on a resident. The investigation into the allegations included: Observations of the environment, resident interactions with staff, and supervision of residents. Interviews with the Administrator, Caregiver, and residents. Record review of three closed resident files, including the resident of concern, including physical exams, activities of daily living, incident reports, staffing schedules, and discharge reports. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: JOSE O. CASTILLO JR, | Title: Administrator | Date: 08/23/2023

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.

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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 observation and interview, the facility failed to ensure the exterior premises were clean and maintained. Findings include: On 07/06/23 at 9:15 AM, the front yard of the home was overgrown with weeds. On 07/06/23 at 9:35 AM, a long table, four full, heavy-duty garbage bags, a plastic bin, various plastic containers, and a broken water hose were stored outside against the house. On 07/06/23 at 9:35 AM, the Caregiver verbalized the facility was in the process of cleaning out the weeds and the items placed next to the house were waiting for garbage pick-up. This was a repeat deficiency from the 09/28/22 annual State Licensure survey. Severity: 2 Scope: 3	0178	Tag #0178 The Facility staff and administrator will make sure that the environmental surroundings will be kept clean and well maintained by scheduling and immediately removing weeds and any garbage and will have a maintenance log checklist to be signed and check in a continuous basis to avoid this from happening again. There was a general cleaning and disposal done after the survey.	08/23/2023
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-	0920	Tag#0920 Medication Management Class are always updated in every caregiver and it is a must to secure residents medication in a locked storage with the right temperature and will be given on a right time, route, medication, person, dose, and documentation. Even refrigerated meds and ensures should be secured at all time with locks to avoid being taken by other residents which is also the same as to caregivers meds. The caregivers were inform to secure all the medication including their medication and were given a refresher by reading the medication books after the survey and the loose meds was kept in a storage where it belongs and the caregivers insulin was put in a lock container to be secured at all time after each use.	08/23/2023

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	counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure the medications were secured for 5 of 5 residents. Findings include: On 07/06/23 at 9:21 AM, a box of diclofenac sodium topical gel 1% was on the kitchen counter. The kitchen area was open and accessible to all residents. On 07/06/23 at 9:21 AM, the Caregiver confirmed the unsecured diclofenac sodium topical gel was on the kitchen counter. The Caregiver acknowledged the unsecured medication found in the kitchen counter belonged to a resident and the Caregiver indicated all medications should be secured. On 07/06/23 at 9:32 AM, one box of Trulicity, two boxes of Ozempic, and four boxes of Humulin were stored in the door of the common refrigerator. The refrigerator was not locked and the medications were not in a locked box. On 07/06/23 at 9:32 AM, the Caregiver verbalized the medications belonged to the Caregiver. The Caregiver verbalized there were residents at the facility who would be able to open the refrigerator and access the medication. Severity: 2 Scope: 3			