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 _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSET RENO ASSISTED LIVING	**6215 SHARLANDS AVE, RENO, NEVADA ,89523**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey and complaint investigation conducted in your facility on 05/20/2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 110 Residential Facility for Group beds for elderly and disabled persons, and/or mental illness and/or providing assisted living services, 80 Category I residents and 30 Category II residents. The census at the time of the survey was 83. 23 resident files were reviewed, including three closed records and 15 employee files were reviewed. The facility received a grade of C. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. One complaint was investigated. Complaint #NV00072726 with the following allegations could not be substantiated due to lack of evidence. Allegation #1: The facility did not follow specialized diets ordered by hospice. Allegation #2: The facility was not ensuring a resident received staff assistance with eating. The investigation into the allegations included: Observations of resident rooms, staff and resident interactions, dining staff and resident interactions, kitchen and dining room operations, food storage, and staff response to resident call lights. Interviews with two residents, the Executive Director,	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MEGAN SALISBURY Title: Administrator Date: 07/18/2025

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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	and the Dietary Director. Review of the facility's Residence and Care Agreement, and the facilities weekly dining menu. 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:			
0871 SS= D	Medication Administration - Plan - NAC 449.2742 and R043-22 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: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician, physician assistant or advanced practice registered nurse or other physician, physician	0871	A new bottle of Vitamin B-12 2,500mcg was brought in for resident #1 on 5/21/25 with expiration date of 11/2027 and was placed in the cart for administration. The bottle without an expiration date was removed from the cart and destroyed. Medication technicians will write the expiration date on the label for all OTC medications in addition to date on the bottle effective immediately. Audits will be completed of the medication carts with the written orders every two weeks for two months, then monthly after effective immediately. These audits will include checking expiration dates. Resident Services Director and Executive Director/ Designee will be responsible for completion of this task. Medication cart audit was completed on 7/15/25 for both carts and will occur again on 7/30/25, 8/13/25, 8/27/25 then on the second Wednesday of every month following.	05/21/2025

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	assistant or advanced practice registered nurseof the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on observation, interview, and document review the Administrator failed to ensure a medication bottle included an expiration date for 1 of 20 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/05/2023, with diagnoses including dementia, atrial fibrillation, and hypertensive heart disease with congestive heart failure. Resident #1's May 2025 Medication Administration Record (MAR) documented Vitamin B-12 2,500 micrograms (mcg), place one tablet under the tongue once daily for supplement. The medication was documented as administered from 05/01/2025 through 05/20/2025. On 05/20/2025 at 2:29 PM, during a review of Resident #1's medications and in the presence of the Executive Director (ED), a bottle of Vitamin B12 for Resident #1 lacked an expiration date. The ED viewed the bottle of medication and verbalized the expiration date appeared to have been rubbed off. The ED verbalized because the			

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	date had been rubbed off, staff were not able to verify if the medication had expired. Severity : 2 Scope : 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on observation, record review and interview the Administrator failed to ensure a Medication Administration Record (MAR) was accurate for 1 of 20 sampled residents (Resident #17). Findings include: Resident #17 Resident #17 was admitted to the facility on 06/01/2023, with diagnoses including anxiety disorder and hypertension. Resident #17's May 2025 MAR, provided by the facility, documented Lorazepam 0.5 milligram (mg) tab, take one tablet by mouth every six hours as needed for anxiety or shortness of breath. On 05/20/2025 at 2:38	0895	Resident # 17’s Lorazepam medication was discontinued on 4/07/25. A copy of the discontinue order was provided to surveyor at time of review. The medication was removed from eMAR on 5/20/25. The medication had already been removed from the cart and destroyed at time of med review. Audits will be completed of the medication carts with the written orders every two weeks for two months, then monthly after effective immediately. A discontinue log has also been created to monitor all discontinued medications and to ensure they are out of the eMAR and the cart when discontinued. This log has been used for all discontinued medications starting on 7/1/25. This log will be reviewed and updated daily by the Resident Services Director or Executive Director/ Designee. Resident Services Director and Executive Director/ Designee will be responsible for completion of medication cart audits. Medication cart audit was completed on 7/15/25 for both carts and will occur again on 7/30/25, 8/13/25, 8/27/25 then on the second Wednesday of every month following.	05/20/2025

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	PM, during a review of Resident #17's medications and in the presence of the Executive Director (ED), Lorazepam was not with the resident's active medications. The ED explained the facility had received an order to discontinue the medication however the medication had not been removed from the resident's MAR. A Physician's Order documented Lorazepam 0.5 mg tablet, take one tablet by mouth every six hours as needed for anxiety for up to 30 days. The start date was 04/12/2024 and the discontinue date was 04/07/2025. Severity : 2 Scope: 1			
0920 SS= E	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-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, interview and document review, the facility failed to ensure medications in a resident room approved to self-administer medications were safely stored in a locked area and inaccessible to other residents or visitors for 4 of 37 sample resident rooms (Rooms #221, #230, #235,	0920	All apartments of residents who receive medication assistance from facility Med tech were audited on 5/27/25. Apartments of residents who self- administer medications were also checked on 5/27/25 to ensure the apartment was locked and/ or medications were secured inside of the apartment. Audits will be completed for this item every two weeks for two months, then monthly after effective immediately. A room audit form will be utilized for each unit during audits to identify medications in apartments, if the medications have a physician's order, if an order is needed or if the medication must be removed. Additionally, apartments of those who self-administer will be checked to ensure doors are locked or medications are secured. Resident Services Director and Executive Director/ Designee will be responsible for completion of room audits. Room audit was completed on 7/16/25 and will occur again on 7/30/25, 8/13/25, 8/27/25 then on the second Tuesday of every month following. Education will also be provided to residents and necessary family members/ friends on what is considered medication and what is required in our community for all medications, as well as to the Med Techs in our community on an ongoing basis.	05/27/2025

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	and #205) and to ensure resident medications were kept secured in the facility for 4 of 20 sampled residents (Resident #8, #13, #18 and #9). Findings include: On 05/20/2025, the following resident rooms contained unsecured medications: Room 221 - at 11:23 AM, a bottle of ibuprofen was on the kitchen counter. The resident verbalized the medicine was stored there, and did not always lock the door when away from the room. Room 230 - at 11:37 AM, the door to the room was unlocked and the room was unoccupied. A bottle of Zicam was in the unlocked medicine cabinet. A bottle of acetaminophen was in the open on the kitchen counter. The designated medicine drawer was unlocked and contained diltiazem, oxybutynin, metoprolol, pantoprazole, and lorazepam. Room 235 - at 11:43 AM, the one of the two occupying residents was present in the room. The room was occupied by spouses. One spouse was approved to self-administer medications, and the other spouse was not approved to self-administer medications. The non-approved spouse was present and verbalized being alone in the room, regularly, and always locking the door when out of the room. The following medications were stored in an open basket, unsecured in the resident bathroom: atorvastatin, ferosul, levothyroxine, lisinopril, aspirin, vitamin D3, vitamin B12. Room 205 - at 11:54 AM, a basket of prescription medications was located in an open basket placed in a space of a television stand, under the television. The resident verbalized always storing medication in that place, and does not lock the door when out of the room. On 05/20/2025 at the time of each discovery, the Maintenance Director confirmed a resident self-administering medication must keep medications always locked. Resident #9 Resident #9 was admitted to the facility on 06/03/2024, with diagnoses including type two diabetes mellitus and hyperlipidemia. On 05/20/2025 at 3:57 PM, an observation of Resident #9's			

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	room was conducted in the presence of both the resident and the Executive Director (ED). The resident resided in a shared suite with Resident #3. The door to enter the suite from the main hallway led into a shared living space and kitchenette. The doors to both resident's bedrooms were accessible from the shared areas. The door to Resident #9's bedroom was unlocked. During the observation of Resident #9's room, the following items were found in the medicine cabinet in the resident's bathroom: -A tube of Salonpas plus Lidocaine cream. -A bottle of Visine lubricant eye drops. -A container of Desitin Zinc Oxide paste. Resident #9 denied the resident typically locked the resident's bedroom door when the resident left. The facility policy titled "Over-the-Counter (OTC) Medications," undated, documented a physician order was required for all OTC medications. OTC preparations were to be centrally stored, documented, and handled in the same manner as prescription medications. Severity : 2 Scope: 2 On 05/20/2025 at 3:40 PM, during room inspections with the Maintenance Director, the following Resident's rooms contained unsecured medications. Resident #8 Resident #8 was admitted to the facility on 05/30/2023, with diagnoses including anxiety, constipation and urinary tract infection. Unsecured medications found in Resident #8's room on kitchen counter: -one bottle of acetaminophen -one bottle of Pepto Bismol -one bottle of Miralax -one tube of bengay -one tube of biotine toothpaste Resident #8 was not in the room, however Resident #8 resided with spouse and Resident #8's spouse verbalized the medications belonging to Resident #8. Resident #8's spouse explained the mediations were always left on the kitchen counter for when Resident #8 needed them. Resident #13 Resident #13 was admitted to the facility on 03/19/2025, with diagnoses including hypertension, constipation, and vertigo. Unsecured medications found in Resident			

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	#13's room: -one bottle of Pepto Bismol -one box of Gental Laxatives Resident #18 Resident #18 was admitted to the facility on 03/11/2025, with diagnoses including neck pain, polyneuropathy, and acid regurgitation. Unsecured medications found in Resident #18's room: -one tube of neosporin -one tube of cortisone cream			

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1505 SS= C	Requirements for posting required information - NAC 449.011921 and R004-24 Requirements for posting certain required information: Contents; size; placement. (NRS 449.0302) The statement required to be posted pursuant to paragraph (b) of subsection 2 of NRS 449.101 and the notice and information required to be posted pursuant to subsection 3 of NRS 449.101 must: (1) Be not less than 8.5 inches in height and 11 inches in width, with margins not greater than 0.5 inches on any side; and (2) Be written using a single typeface in not less than 22-point type. Inspector Comments: Based on observation and interview, the facility failed to ensure nondiscrimination posting and complaint contact information for the Division was posted within the facility or on the facility's Internet website and marketing material. Findings include: On 05/20/2025 at 9:05 AM, the Executive Director was shown the required language for a facility's non-discrimination posting and verbalized the existing posting did not comply with Nevada requirements. On 05/20/2025 at 3:35 PM, the Marketing Director opened the facility's website and verbalized the site lacked the required nondiscrimination information website, used to market the facility. The printed marketing material also lacked documented evidence of information related to nondiscrimination and the contact information for the Division to file a complaint. On 05/20/2025 at 3:35 PM, the Marketing Director verbalized not having been aware of the requirement of a nondiscrimination posting and complaint contact information on the facility's website and marketing material. Severity: 1 Scope: 3	1505	The non- discrimination posting was fixed at time of survey on 5/20/25 by the Executive Director and was shown to surveyor. The surveyor confirmed new posting was appropriate per regulations. Marketing materials were updated to reflect this information on 5/20/25. The Summerset Senior Living website was also updated to include the nondiscrimination information and the contact information for the Division. Executive Director will be responsible for ensuring information on posting, marketing materials and website is updated per state regulations on an ongoing basis.	05/20/2025

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1520 SS= C	Policy on handling of complaints; log of comp - NAC 449.011926 and R004-24 - Policy on handling of complaints; log of complaints. (NRS 449.0302) A facility shall: 1. Develop and adopt a written policy on how a complaint with the facility: (a) May be filed with the facility; and (b) Will be documented, investigated and resolved; and 2. Maintain a log that lists: (a) All complaints concerning prohibited discrimination that are filed with the facility; (b) The actions taken by the facility to investigate and resolve each complaint; and (c) If no action was taken concerning a complaint, an explanation as to why no action was taken. Inspector Comments: Based on document review and interview, the facility failed to develop policies on how to file a complaint with the facility, and how the complaint would be documented, investigated and resolved related to discrimination in the admission of, or services to a resident based wholly or partially on the actual or perceived gender, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. Finding include: On 05/20/2025 at 3:48 PM, the Executive Director confirmed the facility had not developed polices to file a complaint, or how a complaint would be documented, investigated and resolved related to discrimination of a resident based on the actual or perceived gender, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. The Executive Director verbalized not having been aware of this requirement prior to the request during this survey.	1520	A grievance binder was created on 7/14/25 to manage all facility complaints including complaints related to discrimination. This binder includes a log of all complaints filed, grievance forms that describe the complaint and follow up and Summerset's grievance/ complaint policies. Grievance forms have been placed at the front desk to be given to residents, family members or visitors of the community to file complaints effective immediately. The Executive Director is responsible for following up on each complaint filed. The Executive Director will work with the appropriate department head and will follow up on the complaint within 5 days by preferred method of contact. The Executive Director will review complaint forms on a daily basis, will update the complaint log daily and will follow up on all complaints on an ongoing basis.	07/14/2025
1810 SS= F	Infection Control Program - NAC 449.0109 Program and policy for control of infection; designation and training of person	1810	Resident #11 tested positive for C. Diff from a sample collected on 5/13/25. Resident	05/20/2025

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	responsible for infection control. (NRS 439.200, 449.0302) 1.A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and (c) Develop and carry out a comprehensive plan for emergency preparedness. 2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on observation, document review and interview, the Administrator failed to ensure the facility's Infection Control Program was reviewed annually and Centers for Disease Control and Prevention (CDC) guidelines for contact precautions were effectively		was placed on contact precautions on 5/14/25 when results were received. Resident remained on contact precautions through 10-day course of antibiotics which began on 5/16/25. Following survey, trash can was moved from the hallway to inside of resident #11's apartment on 5/20/25. Staff were directed to discard PPE in trashcan with secure lid inside of the apartment and to wash hands after completion of care in the apartment and after exiting the apartment with soap and water. The Infection control program was reviewed on 5/22/25 and signed by the Executive Director. Executive Director will review this plan annually moving forward. The Executive Director will ensure completion of this task utilizing an annual calendar notification. Executive Director reviewed Infection Control Policy and CDC Document “2007 Guidelines for Isolation Precautions: Preventing Transmissions of Infectious Agents in Healthcare Settings” with Resident Services Director and Maintenance Director on 7/8/25. Areas of infection control improvement were identified including placing a trash can inside of the apartment, PPE disposal and proper hand washing procedures. The Executive Director, Resident Services Director and Maintenance Director will be responsible for ensuring proper infection control protocol is followed effective immediately. This will be on an ongoing and case-by-case basis or in case of community outbreak. Education regarding infection control, PPE disposal and proper hand washing procedures provided to all staff at all staff meeting on 7/16/25.	

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		A. BUILDING _____ B. WING _____	**05/20/2025**

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	followed when discarding PPE and performing hand hygiene upon exit from a Clostridium difficile (C. diff) positive room. Findings include: On 05/20/2025 at 11:46 AM, the facility's Infection Prevention and Control Plan, dated 01/13/2022, was provided by the Executive Director. The Infection Prevention and Control Plan lacked documented evidence the plan was reviewed annually. On 05/20/2025 at 3:04 PM, the Executive Director confirmed the facility's Infection Prevention and Control Plan lacked documented evidence of being reviewed annually. Contact Precautions Resident #11 Resident #11 was admitted to the facility on 10/26/2023, with diagnoses including chronic obstructive pulmonary disease and atrial fibrillation. A Result Report dated of 05/14/2025, documented Resident #11's stool specimen was positive for C. diff toxin. Special contact precautions were required and treatment was recommended if the resident was symptomatic. A Physician's Order dated 05/15/2025, documented Fidaxomicin 200 milligram (mg) tablets, take one tablet by mouth two times a day for ten days. The associated diagnosis was C. diff diarrhea. On 05/20/2025 at approximately 4:00 PM, a garbage can and a Personal Protective Equipment (PPE) cart containing gowns and gloves were located in the hallway outside Resident #11's room. A sign was posted near the resident's door indicating contact precautions were in place. The ED verbalized Resident #11 was on contact precautions due to the resident testing positive for C. diff the week prior. The ED denied a garbage can designated for disposal of potentially contaminated PPE was kept in the resident's room. The ED explained staff's process when providing care to Resident #11 included donning a gown, providing care, doffing PPE, and discarding the potentially contaminated PPE in the garbage can in the hallway. On 05/20/2025 at 4:45 PM, the ED verbalized staff had multiple options for locations to			

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	perform hand hygiene when exiting Resident #11's room. Options included the sink in the resident's room, the sink inside the medication storage room, and a restroom in the hallway. The ED acknowledged staff"s use of a sink in the restroom in the hallway or in the medication storage room required staff to touch surfaces such as door handles and keys prior to accessing soap and water required for hand hygiene. The facility's Infection Control Plan dated 01/13/2022, documented all staff and volunteers providing direct care to a resident who had a communicable disease would wear appropriate PPE to prevent exposure to infectious agents or chemicals through the respiratory system, skin, or mucus membranes of the eyes, nose, or mouth. PPE may included gloves, gowns, masks, respirators, shoe coverings, and eye protection. The licensee would consult with a local health official or a licensed medical professional to determine the type of PPE to be used based on the communicable disease present. PPE would be removed and discarded in the nearest appropriate waste receptacle with a tight-fitting cover immediately upon completing a task. There would be separation and care of residents whose illness required separation, including quarantine or isolation, from others. References cited included the following CDC articles: CDC Nursing Homes and Long-Term Care Facilities, CDC Isolation Precautions, CDPH Guidance for Local Health Jurisdictions on Isolation and Quarantine of the General Public. Listed resources for the infection control plan included the Department of Health and Human Services and the CDC. Signage on the CDC website, available for download and print by the public on 05/20/2025, documented providers and staff were to put on gloves and a gown before entering the room and discard the items before exiting the room. The CDC document titled "2007 Guideline for Isolation Precautions:			

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	Preventing Transmission of Infectious Agents in Healthcare Settings," last updated 09/2024, documented C. diff was categorized as epidemiologically important due to wide recognition of its current importance in United States healthcare facilities. C. diff was a major cause of healthcare-associated diarrhea and had been responsible for many large outbreaks in healthcare settings which were extremely difficult to control. Important factors contributing to outbreaks included environmental contamination and hand carriage by healthcare personnel to other patients. Contact precautions were intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which were spread by direct or indirect contact with the patient or the patient's environment. Personnel caring for patients on contact precautions were to wear a gown and gloves for all interactions which may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room was done to contain pathogens. Appendix A of the document indicated contact precautions, in addition to standard precautions, were recommended for patients diagnosed with C. diff. Severity: 2 Scope: 3			
0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e)	0065	Employee #11 completed all required annual trainings between 5/22/25 and 5/28/25 for a total of 13.6 hours with 3 hours of Alzheimer’s training utilizing Relias. An audit was completed by the Business Office Manager on 5/21/25 and all employees were assigned annual trainings 30 days prior to their initial hire date in Relias. Employees will be automatically notified of annual trainings by Relias via email 30 days prior to annual hire date. The Business Office Manager and Executive Director/Designee will be responsible for ensuring annual trainings are updated and that each employee completes these timely	05/28/2025

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

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	Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1 of 15 employees working at the facility received the required eight hours of annual caregiver training (Employee #11). Findings include: Employee #11 Employee #11 was hired by the facility as Caregiver (Resident Care) with a start date of 05/07/2024. Employee #11's personnel file documented caregiver training completed 06/12/2024, but lacked documented evidence of eight hours of annual caregiver training completed in 2025. On 05/20/2025 at 3:25 PM, The Business Office Manager verbalized caregiver training was to be completed annually and confirmed Employee #11 did not have annual caregiver training completed by the hire date anniversary of 05/07/2025. Severity: 2 Scope: 1		on an ongoing basis.	