STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10602	A. BUILDING _____ B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	2320 IONE ROAD, LAS VEGAS, NEVADA ,89183

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 08/15/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 126 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness and/or persons with Alzheimer's disease, Category II residents, and assisted living services. The census at the time of the survey was 74. Fifteen resident files and ten employee files were reviewed. The facility received a grade of B. 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 regulatory deficiencies were identified:	0000		
0050 SS= G	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview, record review, and document review, the facility failed to provide protective supervision for one of 15 sampled residents to ensure a safe environment was maintained for residents, staff, and visitors (Resident #14). Findings include: Resident #14 (R14) R14 was admitted to the facility on 01/05/23 with diagnoses including cerebrovascular accident, hypothyroidism, and atrial fibrillation. R14 was admitted to Assisted Living. The Physician's Statement dated 01/05/23 documented R14 was	0050	TAG 0050 1. R14 was moved to Memory Care on 7/24/2023 to offer a protective and safe environment 2. All residents will be assessed prior to admission and facility will admit and retain stable residents with health conditions that can be safely cared for by Community associates and are congruent with state regulatory guidelines. 3. All residents will have a regular assessment or upon change of condition 4. If a resident exhibits cognitive behavior that threatens their life or the well-being of others, they will be assessed to move to Memory Care with or without the placement form completed by the Doctor 5. In order to protect residents in the future from aggressive residents, 1:1 care will be provided by current staff or Inspired Senior Living will contract with an outside agency to provide 1:1 care even if family is not able or willing to provide such care until the resident is safe in Memory Care at Inspired Senior Living or elsewhere.	08/15/2023

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	confused and disoriented, had Sundowning and combative behaviors, was ambulatory, and required close supervision. The Neuropsychological Consultation dated 01/16/23 documented R14 was oriented only to self, with paranoid ideation, amnesia, and confabulation consistent with Alzheimer's disease. Staff Service Notes documented: -01/14/23 / Day Shift (6:00 AM until 2:00 PM): "(R14) wandering the building, may need reassessed." -01/14/23 / Nocturnal Shift (10:00 PM until 6:00 AM): "(Another employee) and myself realized that the front entrance door can easily be opened, without notice on the radios. I don't want R14 to walk out of the facility unnoticed during the morning hours (early morning). See end of shift report for the times R14 has been in the lobby area. I did periodically check on R14 because I don't want R14 walking out of the facility and be lost or get hurt...R14 is a wanderer during early morning hours." 01/15/23: "Resident is confused, wet R14's pants and lost R14's shoes and didn't remember where." 01/17/23 / 1:30 AM: "Finding R14 downstairs watching TV, R14 claims R14 is waiting for the dining room to open...R14 is up again wandering, looking where everyone is, confused with time." 01/18/23 / 12:35 AM: "R14 sitting in theater room. R14's asking where is R14? Confused, escorted R14 back to R14's room..." 01/19/23 / Nocturnal Shift: "Resident downstairs looking into dining room door, asking why is dining room not opened. Informed R14 dining room opened at 8:00 AM for breakfast. Went upstairs to get R14 a sandwich, drink, chips and banana. R14 ate right away, confused with time, place, and reason why R14 is here, claims R14 doesn't belong here." 15:40 (3:40 AM): "Up again, heading downstairs to lobby." 01/19/23 AM Shift: "Resident just has been wandering around." 01/21/23 PM: "Resident is confused. Reminded R14 to go downstairs for dinner. R14 looked at me and said someone told R14 to come up to go to bed. Very confused. Seen R14 in the lobby area sitting around." 01/23/23 / Nocturnal Shift: "Resident stayed at the lobby from the beginning of my shift to end of shift. R14 was confused about the time		6. Wellness Director and Administrator to be in contact with POA in such an event and notify Doctor as well	

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	and R14 said R14's waiting for dinner and R14 lined up in front of the dining area door. 01/25/23 PM: "Resident was very confused today. Please keep an eye on R14." 02/04/23 / Day Shift: "R14 was screaming this morning about dead people and that R14's door was broken down." 02/08/23: A Physician's Note documented "Resident is being aggressive and agitated towards staff and residents. We have Assisted Living standard placement for R14. Please re-evaluate. He is also awake all night." 02/16/23: A Physician's Note documented "Care staff reported R14 has increased confusion and hallucinations at night. This has been (since) move in. Last night R14 required 1:1 because R14 was trying to exit seek, stating that R14 sees helicopters outside and stating R14 works for an intelligence agency. Please advise." Additional Staff Service Notes documented: -02/19/23 / 7:00 PM: "R14 walked out of the front door after hours, close to the street. I stopped my car and walked R14 back inside to the elevators." 02/20/23: "R14 was found last night 02/19/23 around 7:00 PM outside of the building lost. R14 is a wanderer, we worry about R14's safety living in Assisted Living, we don't lock doors so residents are free to go out. R14 forgets a lot." 02/23/23 / 2:00 PM: A Wellness Director Note documented "Spoke with resident's (family member), explained current situation and options with resident remaining in AL (Assisted Living). (Family member) stated they couldn't sit with R14, can't afford a 1:1, but agrees (with) day programming resident in MC (Memory Care) and having R14 come back to R14's room at night. They want to do this until R14 sees R14's PCP (primary care physician) on 02/27/23 and will have a meeting after appointment to discuss permanent placement. Executive Director updated." -03/23/23 / 11:30 AM: A Staff Service Note documented "R14 wanted to go on the outing but did not have money to pay. R14 became extremely agitated and started yelling at staff. R14 started pushing staff out of the way so R14 could get on the bus. Staff tried redirecting R14 multiple times but it agitated R14 even more. Eventually we told R14 the outing was canceled so R14 would get off the bus. R14			

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	then continued to scream at staff in the lobby." 03/29/23: A Wellness Director Note documented "left voicemail for POA (power of attorney) to discuss plan of care for resident's behaviors for combative / aggressive behaviors, fixating on laundry. Awaiting call back." 04/01/23: A Wellness Director note documented "On 03/30/23 resident began yelling from the hallway. Left message for POA waiting to discuss POC (plan of care), awaiting call back." 04/07/23: A Wellness Director Note documented "R14's behaviors continued. R14 remained with confusion, fixated on laundry. When R14 voluntarily visited memory care R14 was calm and relaxed, engaged in activity and conversation and did not have any reported behaviors." Staff Service Notes documented further: 05/02/23 / 8:00 PM: "Resident being loud and aggressive, also trying (to) enter other residents' rooms." 2:30 AM: "Resident was sleeping in front of wellness office. R14 insisted on sleeping on the floor." 05/03/23 / 2:45 PM: "Resident was wandering hallways yelling and very confused." 05/09/23 / 9:30 PM: "Resident got loud in hallway, started yelling at me to not go down Hall A and tried pushing me." 05/10/23 / 7:00 PM: "Resident was in bad mood yelling to caregivers." 05/11/23 / 9:00 PM: "Resident in common area upstairs being loud and confrontational." 05/14/23 / 6:38 PM: "Resident was in hallway screaming." 05/14/23 / 6:45 PM: "Was doing charting when resident approached and was yelling and was getting aggressive in my face." 05/17/23 / 9:00 PM: "Resident keeps coming up to me upset and loud because I unlocked R14's apt (apartment) with my key." 06/06/23 / 9:00 PM: "Resident was in common area on second floor yelling at the caregivers. Got mad, irritated when we tried to redirect. R14 approached one caregiver very aggressively and waving R14's hands around in caregiver's face." 06/06/23 / 11:00 PM: "Resident got out of bed looking for R14's wife, proceeded to go to first floor and banged on Memory Care doors demanding them to let R14 in. R14 was in a very hostile state." 06/08/23 / 9:30 PM: "Resident awake and walking around the building." 06/16/23: A Physician's Note documented "R14 behavioral issues such			

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	as yelling and screaming with the Caregivers. R14 was also aggressive and irritated for no reason. When we tried to redirect R14, R14 gets mad at the staff." Staff Service Notes documented further: 06/19/23 / 1:00 AM: "Resident got out of bed, got dressed and came down to lobby waiting for an appointment that R14 said was at 10 AM. After explanation of the time it was, R14 went back to R14's room, but came back down for the same thing at 5 AM." 06/21/23 / 8:00 PM: "Resident continues to sit in lobby all day. R14 has been confrontational to visitors, team, and some families. R14 thinks that people are talking about R14 or stealing things from R14. R14 requires a lot of redirection from Concierge and Administrator." 06/22/23 / 11:00 AM: "Resident been downstairs all morning yelling and upset for no reason, was running behind the front desk, Concierge went in the Executive Director's office to get away from R14." 06/22/23 / 3:50 PM: "Resident is very confused and agitated. R14's confused by the door stopper that's on the wall behind the door. R14 keeps coming out to the hallway and saying R14's gonna tear down the wall or blow it up." 06/23/23 / 3:40 PM: A Wellness Director Note documented "Executive Director spoke with POA regarding resident's behaviors and moving to Memory Care. POA agreed to move resident to Memory Care after July 4, 2023 when they are able to come to town to assist with move. PCP faxed to sign standard placement form." 06/26/23: A Wellness Director Note documented "Spoke to POA, made aware that R14 hit another resident's family member and that they needed to provide a 1:1 sitter for resident during waking hours until resident moves to Memory Care. POA stated they would reach out to company currently using to see if they can set up a personal care service for the rest of the days and they would be back in town around July 8 to move resident to Memory Care." 06/28/23: A Physician's Note documented "R14 refused all AM medications. When attempt was made to administer R14 slapped them out of Med Tech's hand." 06/29/23: A Physician's Note documented "R14 refused all AM			

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	medications. When attempts are made to administer R14 gets combative. R14 also grabbed all R14's personal belongings and tried to elope from the facility." 06/29/23 / 10:00 AM: A Wellness Director Note documented "Resident is alert, awake, and confused...R14 is agitated and unpacking R14's room. Awaiting PCP to sign standard placement form. POA wants resident moved to Memory Care as soon as possible. Team continues to provide support and redirection." 07/03/23 / 10:20 PM: A Wellness Director Note documented "Resident continues to have behaviors. R14 was started on antibiotic but has been refusing R14's medications. PCP has been notified and asked to sign standard placement form so resident can move to Memory Care." 07/24/23: A Physician's Note documented "R14 is threatening employee that R14 will kill them. Walking up to residents / staff telling them R14 wants to kill them. Please advise." R14 was moved to the Memory Care Unit on 07/24/23. There was no documented evidence R14 was reevaluated, provided a plan of care and/or permanently placed on the Memory Care Unit for R14's identified aggressive, resistive, confused, fixating, wandering, and elopement behaviors, from 01/14/23 to 07/24/23. On 08/15/23 at 10:00 AM, the Administrator acknowledged R14 was confused with combative, wandering and exit seeking behaviors. The Administrator indicated R14 was not reassessed or transferred to the Memory Care Unit until 07/24/23 because the facility had to wait for the primary care physician to sign off on the standard placement determination form. The Administrator indicated R14 should have been reassessed for placement right after the wandering and aggressive behaviors occurred, and confirmed there was no physician's assessment completed for placement determination until 07/24/23. The Administrator acknowledged the facility policy for safe placement of a resident with aggression and exit seeking behaviors was not followed. On 08/15/23 at 11:00 AM, the Wellness Director verbalized being aware of R14's aggressive behaviors and elopements, which began in February 2023 and indicated the facility had to wait until			

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	the physician signed a standard placement determination form for R14 to be transferred to the Memory Care Unit. The Wellness Director acknowledged R14 needed a secured unit, or to be continuously monitored, specifically on the overnight (nocturnal) shift and R14 had not been provided this when R14 began displaying behaviors. The Wellness Director acknowledged R14 should have been reassessed for placement after the wandering and aggressive behaviors, and confirmed there was no physician's assessment completed for placement determination until 07/24/23. On 08/15/23 at 11:30 AM, the Medication Technician acknowledged R14 should have been residing in the Memory Care Unit upon admission due to the Sundowning behaviors and elopement risk. The facility's policy, Exit Seeking Resident, effective 04/14/23, documented prior to admission all residents will be assessed on admission to the community and periodically as needs change. Residents who are at risk for exit seeking are recommended for placement in the secured memory care neighborhood. Actively exit seeking resident: The resident will be taken to the secured memory care area to prevent resident from exit seeking out of the community. The facility's policy Admission Requirements, effective 04/14/23, documented the facility will admit and retain stable residents with health conditions that can be safely cared for by Community associates and are congruent with state regulatory guidelines. Severity: 3 Scope: 1			

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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 08/15/2023, 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 reach-in refrigerator, cottage cheese was expired 08/01/23. In the walk-in cooler, buttermilk was expired 08/05/23, lemon juice was expired 08/12/23, and a large box of green peppers had mold growth. 2. Major Violations: a. In the deli prep refrigerator, half of an avocado, a partially cut cucumber and an open package of Swiss cheese were stored uncovered and were not labeled or dated. b. Multiple items that had been opened or prepped were not labeled and/or dated throughout the kitchen, such as: cut lettuce, blue cheese, waffles, jelly, and packages of frozen chicken, fish, etc. c. At the start of the inspection, dietary staff were not in hair nets/hair restraints while working in the kitchen. d. The cook's line equipment was soiled with grease and debris on the sides, underneath and behind equipment. e. The floors under equipment and tables throughout the kitchen were soiled with trash and debris. Severity: 2 Scope: 3	0255	TAG 255 1. Dining staff will follow the attached cleaning schedule to ensure that equipment and surfaces are maintained in a clean and sanitary manner. 2. Cooks and Servers will monitor their respective areas of the kitchen for compliance with dating and labeling requirements. See attached schedules. 3. All daily use items (avocado, cut veggies, meats etc) will be disposed of at the end of each shift. Individual containers that have lids will be labeled and dated. Corrected on 8/14/2023. 4. All Items will be stored in original cases or containers or placed in proper containers with proper labeling and dating. Corrected on 8/14/2023. 5. Additional hairnets have been purchased and have been utilized daily since 8/14/2023 and signage has been posted for staff to wear proper head coverings. Corrected on 8/14/2023. 6. Dining Service Director to spot check twice weekly for compliance with cleaning, dating and labeling requirements. 7. Daily walk through/inspection of walk-in/freezer, reach in coolers, dry storage for expired or spoiled items. 8. Weekly walk through to look for expiring items and dispose of prior to expiration date. 9. All staff will be held accountable for proper compliance with food and health training requirements. 10. Floors and cooks line equipment were cleaned on 8/17/2023. 11. Administrator and Food Service Director to spot check weekly for compliance with cleaning, dating and labeling requirements, hair net compliance and cleaning requirements	09/08/2023
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the	0878	TAG 0878 1. A Special Diet Order board with resident photos and names will be kept in the Kitchen area for staff to see who has a special diet (see attached photo) 2. Servers will coordinate with cooks to ensure each residents meal is correct according to the diet order provided by the	08/15/2023

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	facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review, interview, and document review, the facility failed to follow physician instructions for a special diet for 1 of 15 residents (Resident #15). Resident #15 (R15) R15 was admitted on 02/14/23 with a diagnosis of subdural hematoma with evacuation. An incident report dated 06/23/23 documented R15 was choking in the facility dining room, which resulted in the use of the Heimlich maneuver on R15 by R15's family member. The report documented the physician was notified. A document entitled Physicians Communication dated 06/23/23 documented R15 required a chopped/soft		Doctor. 3. Wellness Department to provide new and updated diet orders as the diets change. 4. Dining Service Director to monitor meals and diet order board for correctness weekly or as needed as diets change. 5. Staff received training on Special Diets. See attached training sign in sheets. 6. The Diet was immediately corrected for R#15 with his diet order placed for the dining staff to see. 7. The following is how Diet Changes will be addressed in the Community. This is also attached as a supporting document 1) Order must be received in writing or via electronic process. 2) A copy of the Diet Communication Form will be kept in file in Dining Services office. Maintain copies of written documentation for one year or per community record retention policy. 3) Resident photo and name must be posted on a diet board in a conspicuous place within the kitchen where visible to staff though not visible to guests or residents. Special diet information must also be available in memory care neighborhoods. 4) Diet board must include photos of all residents on a prescribed special diet and/or prescribed allergies. 8. Administrator will spot check meals and diet order board monthly for compliance and correctness.	

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	diet. A Diet Option Communication Form dated 06/30/23, documented a mechanical soft-chopped diet for R15, and was signed and dated by the Wellness Director. On 08/15/23 at 12:30 PM, R15 was observed being served a meal including whole meatballs which had not been cut up into smaller pieces. Later, R15 was served a whole brownie topped with several halved walnuts. The facility's Dining Services policy #935, Special Diet and Diet Communication, documented: 2) The responsible physician or designee i.e. Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist per State regulations, must order the diet in writing. Wellness Department is responsible for communicating to the Dining Services Department: a) All physician/designee-ordered diets, b) Physician/designee-ordered clinical nutrition services and c) Pertinent information regarding Residents and their meals. 3) Diet orders or Resident status information will be communicated via community process. Procedures: 1) Order must be received in writing or via electronic process. 2) A copy of the Diet Communication Form will be kept on file in Dining Services office. Maintain copies of written documentation for one year or per community record retention policy. 3) Resident photo and name must be posted on a diet board in a conspicuous place within the kitchen where visible to staff though not visible to guests or residents. Special diet information must also be available in memory care neighborhoods. 4) Diet board must include photos of all residents on a prescribed special diet and/or prescribed allergies. On 08/15/23 in the morning, a bulletin board in the kitchen documenting special diet needs for residents did not list R15 under the mechanical/soft diet category. On 08/15/23 in the morning, interviews with the Cook and Kitchen Manager confirmed kitchen staff knew of the physician's instructions for the mechanical/soft diet for R15 and acknowledged R15's special diet requirements were not posted on the bulletin board in the kitchen. The Cook reported multiple choking incidents had occurred for R15 since admission and			

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	10602	A. BUILDING _____ B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	2320 IONE ROAD, LAS VEGAS, NEVADA ,89183

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	indicated that the kitchen staff was expected to chop all food for R15. On 08/15/23 at 12:38 PM, the Kitchen Manager acknowledged R15's meatballs should have been cut before being served to R15. The Kitchen Manager reported one cook in the kitchen was not reading R15's special diet requirements ticket accurately, despite repeated instruction R15 required a mechanical soft diet/chopped diet. The Kitchen Manager acknowledged R15 did not receive a mechanical/soft diet/chopped diet as required. On 08/15/23 at 12:40 PM, the Kitchen Manager acknowledged R15 should not have been served whole meatballs and a whole brownie with halved walnuts on top, because it was not a mechanical soft diet/chopped diet per the physician's instructions. On 08/15/23 in the morning, the Director of Dietary Services was not aware of the special diet requirement for R15. Severity: 2 Scope: 1			
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to complete an evaluation of a resident's	0938	TAG 0938 1. All residents will be assessed prior to admission and will admit and retain stable residents with health conditions that can be safely cared for by Community associates and are congruent with state regulatory guidelines. 2. All residents will have a regular assessment or upon change of condition 3. If a resident exhibits cognitive behavior that threatens their life or the well-being of others, they will be assessed to move to Memory Care with or without the placement form completed by the Doctor 4. R14 was moved to Memory Care on 7/24/2023 to offer a protective and safe environment 5. Wellness Director and Administrator to be in contact with POA in such an event and notify Doctor as well	09/08/2023

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	ability to perform the activities of daily living (ADL's) upon admission and after changes in mental condition for one of 15 sampled residents (Resident #14). Findings include: Resident #14 (R14) R14 was admitted to the facility on 01/05/23 with diagnoses including cerebrovascular accident, hypothyroidism, and atrial fibrillation. R14 was admitted to the Assisted Living section - Room 227. R14 was moved to the Memory Care Unit on 07/24/23. The Physician's Assessment included a Standard Placement Form which documented R14's placement in a Residential Facility Groups for elderly or disabled persons in accordance with the needs of a person from old age or disabilities. There was no documented evidence of an ADL evaluation by the facility upon R14's admission. The Staff Service Notes and Physician Communication Notes documented there were six incidents of wandering behaviors, two incidents of aggressive exit seeking, an actual elopement on 02/19/23, and three verbally abusive and physically combative behaviors from the time of admission through 04/13/23. There was no documented evidence the facility completed an ADL's evaluation for any of these documented changes in R14's condition prior to 04/13/23. A Service Plan developed 04/13/23 documented, Neurocognitive: Orientation: Mild Impairment: Resident has current or history of occasional difficulty remembering and using information; requires some directions and reminding from others. Psychosocial: Minimal Wandering Issues: Resident has current or history of wandering that does not jeopardize safety. The Service Plan dated 04/13/23 did not accurately document R14's impairment related to wandering, elopement, orientation, and behaviors. The Staff Service Notes and Physician Communication Notes documented there were five incidents of wandering behaviors and 15 incidents of verbally abusive and physically combative behaviors from 04/13/23 through 07/24/23. R14 hit another resident's family member on 06/26/23. There was no documented evidence the facility completed an ADL's evaluation for			

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	any of these documented changes in R14's condition prior to 07/24/23. On 08/15/23 at 10:00 AM, the Wellness Director acknowledged while residing in the Assisted Living Unit, R14 had significant dementia, wandered from the facility, had yelling and screaming behaviors, and was at times very resistive and combative prior to being moved to the secured Memory Care Unit on 07/24/23. On 08/17/23, the Administrator verified the facility did not complete an ADL evaluation upon admission and after R14 displayed a change of condition by wandering and displaying aggressive behaviors until 04/13/23, and an updated Service Plan / Plan of Care was not completed by the facility until 07/24/23. The facility's policy, Exit Seeking Resident, effective 04/14/23, documented prior to admission all residents will be assessed on admission to the community and periodically as needs change. The facility's policy, Admission Requirements, dated 04/14/23 documented the facility will admit and retain stable residents with health conditions that can be safely cared for by Community associates and are congruent with state regulatory guidelines. Severity: 2 Scope: 1			

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1050 SS= D	Vital Signs-Glucose - Training/Competency - NAC 449.1985 (1)(a) 1. A caregiver of a residential facility may perform a task described in NRS 449.0304 if the caregiver: (a) Before performing the task, annually thereafter and when any device used for performing the task is changed: (1) Has received training concerning the task that meets the requirements of subsections 5 and 6; and (2) Has demonstrated an understanding of the manner in which the task must be performed; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 sampled Medication Technicians were trained in administering insulin injections and conducting glucose testing (Employee #5). Findings include: Employee #5 (E5) was hired as a Medication Technician on 11/03/22. E5's file lacked documented evidence of training in conducting glucose checks and the administration of a pre-filled insulin pen. The August 2023 Medication Administration Record (MAR) for Resident #2 (R2) documented glucose testing and administration of a pre-filled insulin pen was conducted twice a day. The Medication Technician on duty reported the Medication Technicians were conducting the glucose checks and administering insulin to the resident twice a day. The Wellness Director indicated staff were supposed to be trained in conducting glucose testing and the administration of a pre-filled insulin pen before performing the task. The Business Office acknowledged E5 was not trained in conducting glucose testing and the administration of a pre-filled insulin pen and was unable to provide documented evidence. Scope: 2 Severity: 1	1050	TAG 1050 1. 1. Staff member received training on 8/22/2023 for Glucose Testing and administration. See attached documentation from training location .. 2. The Business Office Director will, upon hire, verify whether a Medication Technician has the Glucose Testing and Administration certification. 3. The Business Office Director will ensure that any Medication Technicians that are trained from existing staff complete the Glucose Testing and Administration and receive such certification. 3. 4. The Business Office Director will ensure that Medication Technicians complete their annual recertification prior to their certification expiring by using an excel spread sheet. 4. 5. Administrator to spot check Medication Technician’s files for compliance.	08/22/2023