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 _____	**05/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	**3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation completed in your facility on 04/25/24 and finalized on 05/21/24, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility was licensed for 150 Residential Facility for Group beds for elderly or disabled persons, and/or persons with intellectual disabilities, and/or persons with Alzheimer's disease, and/or Assisted Living Services, Category II residents. The census at the time of the survey was 114. Twenty-five resident records and ten employee records were reviewed. The facility received a grade of D. There was one complaint investigated. Substantiated Without Deficient Practice: 1. Complaint #NV00070984 was substantiated without deficient practice. The investigation into the complaint included: Observations of resident rooms, interactions between staff and residents, residents in the Dining Room during lunch and residents receiving medications. Interviews conducted with residents, Caregivers, a Medication Technician, a Housekeeper, the Dietary Manager/Executive Chef, the Sous Chef, the Wellness Director and the Administrator. Record review of residents, including the resident of concern. Document review including facility policies and procedures, job descriptions and the Resident Services Agreement. 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	Administrator's Responsibilities - Oversight -	0050	1. Resident #23 has been issued a 30 Day	06/25/202

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: HEATHER LANKFORD | Title: Executive Director | Date: 06/26/2024

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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SS= D	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 observation, interview, record review, and document review, the Administrator failed to provide oversight to ensure a resident with unmanageable, non-compliant behaviors and wounds was provided with needed services (Resident #23). Findings include: Resident #23 (R23) R23 was admitted to the facility on 03/29/23 with diagnoses including chronic deep vein thrombosis of the lower extremities, psoriasis, bipolar disorder, anxiety, and depression. On 04/25/24 at 11:00 AM, R23 was observed in their room in the electric wheelchair. R23's lower legs were red, swollen, and had multiple red, scabbed over sores. On 04/25/24 at 12:30 PM, the Health Services Director (HSD) and the Administrator indicated not being aware R23 had open wounds on the lower legs. The HSD and the Administrator did not know what caused the sores/wounds, what type, if any, treatment was being provided by a medical professional, and whether R23's condition was stable. After review of the record with the HSD and the Administrator, they indicated the sores might be caused by the psoriasis, and R23 might be getting treatment by the Veteran's Administration. On 04/26/24 at 12:00 PM, the Administrator verified they did not have any information regarding the wounds or wound treatment. On 05/21/24 at 9:30 AM, the Administrator and the HSD verbalized they did not obtain any medical information regarding the wounds or wound treatment. On 04/25/24 at 9:53 AM, the wall next to the bed had large		Move Out Notice due to non-compliance with cleanliness, inappropriate behaviors and not complying with the History & Physical needs. Community will assist him in identifying housing options. 2. Staff have been in-serviced on the following topics: Assessments and Service Plans, Change of Condition Reporting, Cleaning Resident Apartments, Managing Aggressive Behavior, Skin/Wound Management & Urinary Incontinence. Resident behaviors and change of conditions will be discussed daily at shift changes with Caregivers, Med Techs, Resident Care Coordinators and Health Services Director and Memory Care Director and during the Weekly Care / At Risk meeting with Executive Director, Health Services Director, Memory Care Director and AL & Traditions Resident Care Coordinators. 3. Executive Director and Health Services Director will discuss Residents at the Weekly Care / At Risk Meetings that have been addressed at the shift change meetings. Those identified will be placed on the Weekly Care Report with a Plan for that concern. 4. Executive Director and Health Services Director will monitor for compliance. 5. 06.25.2024	4

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	brown stains, identified by the Maintenance Director as spit stains. There were two half-filled open urinals with no covers (one on top of the mattress and one on a counter next to the sink). The toilet seat had smeared, dried feces on top of it. There was feces on the bathroom floor. The bedroom and bathroom had a strong urine odor throughout. On 04/25/24 at 10:00 AM, the Maintenance Director indicated R23 regularly spit on the wall and urinated on the carpet, and the carpet was cleaned once or twice a week. The Maintenance Director verified R23's room always smelled of urine due to R23 urinating on the sheets every night and regularly urinating on the carpet. On 04/25/24 at 10:45 AM, a Housekeeper confirmed R23's room smelled like urine all the time due to R23's bladder accidents on the sheets every night and urinating on the carpet. The Housekeeper indicated ever since they started working at the facility nine months ago, there were dried brown stains on the wall due to R23 spitting on the wall. The Housekeeper indicated R23 did not receive daily assistance with the sheets and cleaning the bathroom, R23 only received twice a week services. On 04/25/24 at 11:05 AM, R23 indicated the facility staff cleaned the room, sheets, and bathroom twice a week. On 04/25/24 at 11:15 AM, the Housekeeper for the Laundry Department verified R23's sheets were not cleaned daily. The Housekeeper indicated R23 stuffed their sheets in the closet laundry basket, and the soiled sheets were only removed from the closet two times a week for laundering. On 04/25/24 at 12:00 PM, the Administrator verified R23 did not receive daily assistance with changing sheets, cleaning the bed, and cleaning the bathroom due to zero points on the facilities point system. The point system determined how much each resident paid for assistance. The Administrator verified they were aware of R23's urinary and fecal odors in the room, but there was no			

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	comprehensive assessment related to R23. On 04/25/24 at 11:15 AM, the Health Services Director (HSD) acknowledged R23 regularly had incidents of urinating on the floor in their room instead of the bathroom, and was not able to self-maintain their room in a sanitary manner. The HSD indicated the facility did not assist in the daily cleaning of the bed, sheets, and bathroom. On 05/21/24 at 9:20 AM, the HSD indicated R23 was refusing assistance to and from the bathroom, refused to wear incontinence briefs, urinated on the carpet regularly throughout the day, and was not motivated to use the toilet. The HSD verbalized not knowing to what extent R23 had a urinary incontinent medical condition and indicated the problem was most likely behavioral. On 05/21/24 at 9:30 AM, the Administrator and the HSD confirmed they did not have training to deal with a resident with non-compliant, unmanageable toileting hygiene behaviors. The HSD indicated they had repeatedly asked R23 to get a physical assessment by R23's physician, and R23 did not provide it. The facility's policy regarding incontinence management, revised December 2013, documented information regarding the resident's urinary history of incontinence - any episodes or ongoing incontinence would be obtained as part of the comprehensive needs assessment at the time of move-in and through on-going routine assessments. Severity: 2 Scope: 1			
0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure	0174	1. Resident #23 has been issued a 30 Day Move Out Notice due to non-compliance with cleanliness, inappropriate behaviors and not complying with the History & Physical needs. Community will assist him in identifying housing options. 2. Staff have been in-serviced on the following topics: Assessments and Service Plans, Change of Condition Reporting, Cleaning Resident Apartments, Managing Aggressive Behavior, Skin/Wound Management & Urinary Incontinence. Resident behaviors and change of	07/26/2024

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	the facility was free of offensive odors, sanitary hazards, and safety hazards. Findings include: On 04/25/24 at 9:56 AM, Room 232 had a sticky floor, dirty wall, stained and torn carpet, urine smell, and brown substance smeared on toilet and bathroom floor. On 04/25/24 at 9:56 AM, Resident #23's (R23) room and bathroom smelled of urine. Two open hand-held urinals were found in the room, one on the resident's bed, and one on the counter by the sink outside the bathroom. The bathroom floor was sticky, the carpet was stained, and there was smeared, dried feces on the toilet seat and on the floor. The wall adjacent to the bed had large reddish-brown stains, which the Maintenance Director identified as spit stains by R23.The carpet in R23's room was ripped at the seam where the carpet met the laminate floor, creating a tripping hazard. On 04/25/24 at 9:57 AM, the Maintenance Director acknowledged the smell of urine in R23's room and explained the urine had seeped into the carpet. The Maintenance Director commented the carpet needed shampooing once or twice a week, and reported tears in the carpet had been fixed twice in the last six months. On 04/25/24 at 10:45 AM, a housekeeper indicated R23 dumped their urine from the urinals into the sink outside the bathroom. In addition, the housekeeper reported R23 dirtied their bedsheets, took them off the bed, and put them in the laundry basket in the closet, where they generally stayed until R23's laundry day. The housekeeper reported R23's bed sheets were changed twice a week, and R23's laundry was cleaned twice a week. The housekeeper shared they had submitted a work order for the torn carpet two to three weeks ago. On 04/25/24 at 11:00 AM, in the Memory Care Unit there was a door leading from a dining/activity area to an outside courtyard. When the door was opened to the outside, the door alarmed and when the door closed the alarm would shut off. When exiting this door		conditions will be discussed daily at shift changes with Caregivers, Med Techs, Resident Care Coordinators and Health Services Director and Memory Care Director and during the Weekly Care / At Risk meeting with Executive Director, Health Services Director, Memory Care Director and AL & Traditions Resident Care Coordinators. 3. Executive Director and Health Services Director will discuss Residents at the Weekly Care / At Risk Meetings that have been addressed at the shift change meetings. Those identified will be placed on the Weekly Care Report with a Plan for that concern. 4. Executive Director and Health Services Director will monitor for compliance. 5. 06.25.2024 Memory Care Unit Door 1. Oakmont Home Office is checking if the doors have the ability to be re-programmed so that when you are in the Memory Care Courtyard you can open the door to gain entry to the dining/activity room via the door handle. Without the need for a staff member to use the keypad. We are in discussions to see if that is the safer option than the risk of a Resident being in the courtyard and not able to gain entry back into the community. 2. Daily shift completion of the Door Security Checklist to ensure that the door is working properly. 3. Daily shift completion of the Door Security Checklist to ensure that the door is working properly. 4. Executive Director and Memory Care Director will monitor for compliance. 5. 07.26.2024	

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	it was observed the door was locked from the outside, needed a code to re-enter, preventing anyone from re-entering the facility. This left the possibility of a resident exiting the building and prevented them from being able to return. This posed a safety hazard to residents in the Memory Care Unit, especially in extreme weather conditions. On 04/25/24 at 11:45 AM, the Maintenance Director and the Administrator acknowledged the door leading from the exterior of the courtyard to inside the Memory Care Unit was locked, and residents were unable to re-enter the facility without a code. Severity: 2 Scope: 3			
0220 SS= E	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on observation and interview, the Administrator failed to ensure 2 of 4 laundry rooms were maintained. Findings include: On 04/25/24 in the morning, three washing machines were out of service or leaking: - One of five washing machines located in the second	0220	1. Service Call from AJ Industries on 05.01.2024 concluded that washer #2 on the west side of the community was working. Test ran unit and found no leaks. Washer #2 on the East side of the community found a bad belt and drain. Both were replaced. Test ran unit and also found bad motor. Washer on the east side of the community was replaced with a new one that was delivered and installed on 05.13.2024. In total two washers were in working condition with no leaks. One had bad belt, drain and those parts were replaced. Motor was bad and washer was replaced with a new one vs. repairs due to the costs. 2. Staff have been inserviced on reporting broken equipment and identifying safety hazards, such as water on the floors. 3. Executive Director and Maintenance Director will check laundry rooms on daily walks in the community for First Impressions. 4. Executive Director and Maintenance Director will monitor for compliance. 5. 06.19.2024	06/19/2024

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	floor west side laundry room was leaking. A towel was pushed up against the washing machine to absorb the excess water. The Maintenance Director was not aware the washing machine had been leaking. - Two of two washing machines located in the second floor east side laundry room were in need of repair. One washing machine had an "Out of Service" sign on the top of the washer, and the other washing machine was leaking onto the floor. The Maintenance Director was not aware the second machine was leaking, and indicated the laundry room should have been closed. On 04/25/24 in the morning, the Maintenance Director acknowledged the washing machines were in need of repair. Severity: 2 Scope: 2			
0255 SS= E	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 04/25/2024, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. A small disposable cup was used as a scoop to dispense bulk sugar and was stored in the bulk container of sugar touching the product. b. There was heavy grease build-up on the cook's line ventilation hood filters; debris and grease build-up under the grill; and there was spillage in the drawer refrigerator. c. The floor in the memory care serving kitchen was soiled with debris and spillage. d. The poured seamless floor in the kitchen was heavily worn through the top coat and wear layers with concrete exposed on the cook's line and in the dish wash area. Severity: 2 Scope: 2	0255	1. Disposable cup was removed from sugar container, cook's line ventilation hood filters were cleaned, debris and grease build up under the grill was cleaned and drawer refrigerator spillage was cleaned. In Memory Care serving kitchen the floor was cleaned from spillage and debris. Main kitchen - poured seamless floor on the cook's line and in the dish wash area is going to be repaired by a vendor called Craft Contracting. We are in the process of finalizing a bid and get on the schedule for repairs. Project deadline will be 30 days from now, unless scheduling does not permit. 2. Culinary Staff were inserviced on 06.19.2024 regarding the kitchen inspection report. 3. Executive Chef will inspect cleanliness of equipment and procedures during kitchen walk and discuss with staff as needed. 4. Executive Director and Executive Chef will monitor for compliance. 5. 07.27.2024	07/27/2024

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0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure a medical exemption request was submitted to the Bureau to retain 1 of 25 sampled residents with an ileostomy (Resident #6) and the facility failed to ensure a medical exemption request was submitted to the Bureau to retain 1 of 25 sampled residents with wounds and who were bedfast (Resident #22) . Findings include: Resident #6 (R6) R6 was admitted on 09/30/22, with diagnoses including dementia and an ileostomy. R6's record revealed R6 had an ileostomy upon admittance. On 04/25/24 in the morning, R6 was interviewed but was very hard of hearing and could only acknowledge they had the ileostomy. R6's spouse resides in the same unit but was not available to be interviewed. On 04/25/24 in the morning, two Caregivers and a Medication Technician verbalized R6 could manage their own ileostomy with the assistance of their spouse who resides in the same unit. The staff verbalized R6's daughter and son manage all the medical appointments and maintenance of the ileostomy. R6's file lacked documented evidence of an application for submission and/or an approved medical exemption for an ileostomy. On 04/25/24 in the morning, the Administrator confirmed they had not applied for a medical exemption request for R6's ileostomy. Resident #22 (R22) R22 was admitted on 11/23/21, with diagnoses including chronic obstructive pulmonary disease and hypothyroidism. R22's record	0830	1. R#6 has been evaluated for Hospice and does not meet criteria. He is on Home Health and is only being allotted so many visits to care for the ileostomy. Home Health will not provide continuous care for this. Community will not be able to meet the requirements of the medical wavier exemption. Community has issued a 30 day move out notice and will assist the family and Resident in finding the appropriate level of care needed. R#22 is receiving Home Health for her wounds, but once healed she will be discharged from Home Health and will not meet the requirements of the medical wavier exemption. She was evaluated for Hospice services on 06.25.2024 and meets Hospice criteria for admission. POA is signing the consent forms on 06.26.2024. Once admission paperwork is complete community will submit the request for medical exemption for wounds and bedfast. 2. Residents that require a medical exemption will be identified and discussed in the Weekly Care / At Risk Meeting. At that time an application will be processed for the medical waiver exemption. 3. All Residents are discussed at the Weekly Care / At Risk Meeting to identify those with increased care needs and those at risk for discharge. Executive Director and Health Services Director lead the meeting with AL Resident Care Coordinator and Traditions Resident Care Coordinator along with the Memory Care Director. 4. Executive Director and Health Services Director will monitor for compliance. 5. 06.26.2024	06/26/2024

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	revealed R22 had open wounds on their left leg and left heel. R22's record revealed home health provided wound care twice a week and noted the wounds were healing appropriately. On 04/25/24 in the morning, R22 was observed lying in bed, well groomed and appeared comfortable. R22 was positioned with pillows on their sides and under their legs. On 04/25/24 in the morning, R22 verbalized they did not know who came in to take care of their wounds and change their dressings. R22 verbalized they could not position themselves in the bed without assistance. On 04/25/24 in the morning, a Medication Technician verbalized they do not assist with R22's wounds and that home health comes in twice a week to change R22's dressings. The Medication Technician acknowledged R22 was bedfast and could not position themselves in the bed without assistance. R22's file lacked documented evidence of an application for submission and/or an approved medical exemption for open wounds and for being bedfast. Severity: 2 Scope: 1			
0840 SS= D	Review of Medical Condition of Resident - NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.0302) 1. If, after conducting an inspection or investigation of a residential facility, the Bureau determines that it is necessary to review the medical condition of a resident, the Bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the Bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the Bureau, provide to the Bureau: (a) The assessments made by physicians concerning the physical and mental condition of the resident; and (b) Copies of prescriptions for medication or orders of physicians for services or equipment necessary to provide care for the resident.	0840	1. Resident #23 has been issued a 30 Day Move Out Notice due to non-compliance with cleanliness, inappropriate behaviors and not complying with the History & Physical needs. Community will assist him in identifying housing options. 2. Staff have been in-serviced on the following topics: Assessments and Service Plans, Change of Condition Reporting, Cleaning Resident Apartments, Managing Aggressive Behavior, Skin/Wound Management & Urinary Incontinence. Resident behaviors and change of conditions will be discussed daily at shift changes with Caregivers, Med Techs, Resident Care Coordinators and Health Services Director and Memory Care Director and during the Weekly Care / At Risk meeting with Executive Director, Health Services Director, Memory Care Director and AL & Traditions Resident Care Coordinators.	06/25/2024

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	Inspector Comments: Based on interview and record review, the Bureau of Health Care Quality and Compliance (HCQC) determined a current review by a physician of the physical and mental condition of 1 of 5 sampled residents was necessary (Resident #23). Findings include: Resident #23 (R23) R23 was admitted to the facility on 03/29/23 with diagnoses including chronic deep vein thrombosis of the lower extremities, psoriasis, bipolar disorder, anxiety, and depression. On 04/25/24 at 11:00 AM, R23 was observed in their room in the electric wheelchair. R23's lower legs were red, swollen, and had multiple red, scabbed over sores. On 04/25/24 at 12:30 PM, the Health Services Director (HSD) and the Administrator indicated not being aware R23 had open wounds on the lower legs. The HSD and the Administrator did not know what caused the sores/wounds, what type, if any, treatment was being provided by a medical professional, and whether R23's condition was stable. After review of the record with the HSD and the Administrator, they indicated the sores might be caused by the psoriasis, and R23 might be getting treatment by the Veteran's Administration. On 04/26/24 at 12:00 PM, the Administrator verified they did not have any information regarding the wounds or wound treatment. On 04/25/24 at 9:53 AM, the wall next to R23's bed had large brown stains, identified by the Maintenance Director as spit stains. The toilet seat had smeared, dried feces on top of it. There was feces on the bathroom floor. The bedroom and bathroom had a strong urine odor throughout. On 04/25/24 at 10:00 AM, the Maintenance Director indicated R23 regularly spit on the wall and urinated on the carpet, and the carpet was cleaned once or twice a week. The Maintenance Director verified R23's room always smelled of urine due to R23 urinating on the sheets every night and regularly urinating on the carpet. On 04/25/24 at 10:45 AM, a		3. Executive Director and Health Services Director will discuss Residents at the Weekly Care / At Risk Meetings that have been addressed at the shift change meetings. Those identified will be placed on the Weekly Care Report with a Plan for that concern. 4. Executive Director and Health Services Director will monitor for compliance. 5. 06.25.2024	

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		A. BUILDING _____ B. WING _____	**05/21/2024**

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	Housekeeper confirmed R23's room smelled like urine all the time due to R23's bladder accidents on the sheets every night and urinating on the carpet. The Housekeeper indicated ever since they started working at the facility nine months ago, there were dried brown stains on the wall due to R23 spitting on the wall. The Housekeeper indicated R23 did not receive daily assistance with the sheets and cleaning the bathroom, R23 only received twice a week services. On 04/25/24 at 11:15 AM, the Housekeeper for the Laundry Department verified R23's sheets were not cleaned daily. The Housekeeper indicated R23 stuffed their sheets in the closet laundry basket, and the soiled sheets were only removed from the closet two times a week for laundering. On 04/25/24 at 12:00 PM, the Administrator verified they were aware of R23's urinary and fecal odors in the room, but there was no comprehensive assessment related to R23. On 04/25/24 at 11:15 AM, the Health Services Director (HSD) acknowledged R23 regularly had incidents of urinating on the floor in their room instead of the bathroom, and was not able to self-maintain their room in a sanitary manner. On 04/25/24 in the afternoon, the Health Services Director was unable to provide documentation of a current physical examination for R23. On 05/21/24 at 9:30 AM, the Administrator and the HSD verbalized they did not obtain any medical information regarding the wounds or wound treatment. On 05/21/24 at 9:20 AM, the HSD indicated R23 was refusing assistance to and from the bathroom, refused to wear incontinence briefs, urinated on the carpet regularly throughout the day, and was not motivated to use the toilet. The HSD verbalized not knowing to what extent R23 had a urinary incontinent medical condition and indicated the problem was most likely behavioral. On 05/21/24 at 9:30 AM, the Administrator and the HSD confirmed they did not have training to deal with a resident with non-compliant, unmanageable toileting			

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	hygiene behaviors. The HSD indicated they had repeatedly asked R23 to get a physical assessment by R23's physician, and R23 did not provide it. The facility's policy regarding incontinence management, revised December 2013, documented information regarding the resident's urinary history of incontinence - any episodes or ongoing incontinence would be obtained as part of the comprehensive needs assessment at the time of move-in and through on-going routine assessments. Severity: 2 Scope: 1			

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0874 SS= F	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the facility failed to ensure six-month Medication Reviews were initialed and dated by the Administrator within 72 hours for all residents requiring a six-month Medication Review. Findings include: On 04/25/24 in the morning, the Health Services Coordinator revealed a folder containing residents six-month Medication reviews dated 02/24/24. A second folder revealed residents' six-month Medication reviews dated 08/29/23. The six-month Medication Reviews lacked evidence of the Administrator reviewing, initialing and dating the six-month Medication Reviews within 72 hours. On 04/25/24 in the morning, the Health Services Coordinator acknowledged the six-month Medication Reviews were not initialed or dated by the Administrator. On 04/25/24 in the afternoon, the Administrator acknowledged the six-month Medication Reviews should have been initialed and dated by the Administrator within 72 hours. Severity: 2 Scope: 3	0874	1. Contracted Pharmacy, Consonus Pharmacy will conduct six-month Medication Review on 06.25.2024. Report was received and Executive Director signed the reports on 06.26.2024. Resident Care Coordinators will reach out to Resident's Physicians if a recommendation is indicated, within the 72 hours requirement of notification. (Pharmacist's Recommendation to Prescriber) 2. Community has changed our Pharmacy vendor and now contract with Consonus. Consonus will conduct quarterly Medication Reviews. Executive Director and Health Services Director have the Medication Reviews on a recurring tickler reminder via Outlook. 3. Executive Director and Heath Services Director will monitor the recurring ticker monthly to ensure compliance with Medication Review task. 4. Executive Director and Health Services Director will monitor for compliance. 5. 06.27.2024	06/27/2024
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	0938	1. All Assessments were completed and up to date. Correction is to ensure Assessments are printed upon completion and placed in the Resident file. Resident #1 Initial Assessment on 09.02.2022, Periodic Assessment 09.28.2022, Change of Condition Assessment 04.24.2023, Periodic	06/25/2024

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	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 ensure Activities of Daily Living (ADLs) were assessed annually for 5 of 25 sampled residents. (Resident #1, Resident #7, Resident #12, Resident #18, and Resident #20). Findings include: Resident #1 (R1) R1 was admitted on 08/31/2022 with diagnosis including multiple myeloma, benign prostate hypertrophy (BPH) and gastro-esophageal reflux disease (GERD). Review of R1's file revealed R1 had an ADL assessment on 08/24/2022. There was no documentation an ADL assessment was completed for R1 in 2023. Resident #7 (R7) R7 was admitted on 01/24/19 with diagnoses including peripheral neuropathy and hypertension. Review of R7's file revealed R7 last had an ADL assessment on 04/19/23. There was no documentation an ADL assessment was completed for R7 in 2024. Resident #12 (R12) R12 was admitted on 02/28/2022 with diagnosis including pneumocystis pneumonia (PCP). Review of R12's file revealed R12 last had an ADL assessment on 02/28/2022. There was no documentation an ADL assessment was completed for R12 in 2023 and 2024.		Assessment 10.19.2023, Periodic Assessment 04.14.2024 and Periodic Assessment 06.02.2024. Resident #7 Periodic Assessment 04.16.2024 and Periodic Assessment 06.03.2024. Resident #12 Initial Assessment 03.02.2022, Periodic Assessment 03.28.2022, Change of Condition Assessment 04.27.2022, Periodic Assessment 11.16.2022, Periodic Assessment 06.14.2023 and Periodic Assessment 01.01.2024. Resident #18 Periodic Assessment 12.28.2018, Periodic Assessment 05.20.2019, Periodic Assessment 11.15.2019, Periodic Assessment 05.13.2020, Periodic Assessment 11.02.2020, Periodic Assessment 05.01.2021, Periodic Assessment 10.22.2021, Periodic Assessment 04.28.2022, Periodic Assessment 11.15.2022, Periodic Assessment 06.08.2023, Periodic Assessment 12.17.2023, Periodic Assessment 12.28.2023 and Periodic Assessment 06.25.2024. Resident #20 Periodic Assessment 03.25.2020, Change of Condition Assessment 04.24.2020, Periodic Assessment 11.23.2020, Periodic Assessment 01.01.2021, Periodic Assessment 06.30.2021, Change of Conditin Assessment 12.29.2021, Periodic Assessment 07.05.2022, Periodic Assessment 01.30.2023, Periodic Assessment 09.06.2023, Periodic Assessment 12.22.2023, Periodic Assessment 03.13.2024 and Periodic Assessment 05.22.2024. 2. Systems and policy are already in place. Assessments & Service Plans Policy #102 and Change of Condition Reporting Policy #301. Assessments are to be printed and placed in Resident file upon completion. 3. Assessment dashboard reflects when assessments are due. Health Services Director checks dashboard daily for work flow management. 4. Executive Director and Health Services Director will monitor for compliance. 5. Assessments were in the computer and	

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	Resident #18 (R18) R18 was admitted on 10/20/2016 with diagnosis including macular degeneration, hypertension and deafness. Review of R18's file revealed R18 last had an ADL assessment on 10/20/2016. There was no documentation an ADL assessment was completed for R18 for 2024. Resident #20 (R20) R20 was admitted on 03/14/2020 with diagnosis including atrial fibrillation and chronic obstructive pulmonary disease (COPD). Review of R20's file revealed R20 last had an ADL assessment on 03/14/2020. There was no documentation an ADL assessment was completed for R20 2023 and 2024. On 04/25/2024 in the afternoon, the Administrator confirmed ADL assessments for R1, R7, R12, R18 and R20 had not been completed in the last year. Severity: 2 Scope: 2		have been printed and added to the Resident file. 06.25.2024	

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1010 SS= D	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on interview, record review, and document review, the facility failed to obtain an endorsement to provide care for persons with mental illness. Findings include: On 04/25/24 during the annual State Licensure survey, it was identified the facility admitted and retained a resident with a diagnosis of bipolar disorder and behavioral issues. (See TAG Y050.) The facility's license did not have an endorsement to provide care for persons with mental illness. On 05/21/24 at 9:30 AM, it was verified with the Administrator that the facility did not obtain an endorsement for mentally ill persons. Severity: 2 Scope: 1	1010	1. Facility applied for Mental Illness Endorsement on 06.11.2024. 2. Executive Director will monitor license renewal application to ensure that Mental Illness Endorsement is applied for on facility license renewal annually. 3. Executive Director will monitor license renewal application to ensure that Mental Illness Endorsement is applied for on facility license renewal annually. 4. Executive Director will monitor for compliance. 5. Application for Mental Illness Endorsement was completed and submitted on 06.11.2024. 6. See attachment of Application Submission.	06/11/2024

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1830 SS= D	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by 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, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the secondary infection control designee completed 15 hours of infection control training from a nationally recognized organization (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 12/03/23 as the Health Service Coordinator. E2's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. On 04/25/24 in the afternoon, the Administrator confirmed E2 was the secondary infection control program designee. The Administrator acknowledged E2's files lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. Severity: 2 Scope: 1	1830	1. Employee #2 completed 15 hours of infection control training from a nationally recognized organization. See attached certificate of trainings from Project First Line / CDC. 2. Business Office Director will add this training requirement to the ADP Training tickler checklist so it will alert us of upcoming training requirement due dates. 3. Business Office Director will monitor ADP Training tickler and remind staff members of upcoming due / renewal dates for required trainings. 4. Executive Director and Business Office Director will monitor for compliance. 5. 06.21.2024	06/21/2024