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 _____	**01/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON VALLEY SENIOR LIVING	**1189 KIMMERLING RD, GARDNERVILLE, NEVADA ,89460**

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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 a complaint survey conducted at your facility on 01/19/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 86 Residential Facility for Group beds, of which 64 beds provided services to elderly or disabled persons and assisted living services, Category II residents, and 22 beds which provided care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 71. Fifteen resident records and ten employee records were reviewed. The facility received a grade of D. 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. There was one complaint investigated. Complaint #NV00067446 with the following allegations could not be substantiated due to lack of evidence: Allegation #1: The facility failed to ensure a Medication Assistant had current medication management training while administering medications to residents. The investigation into the allegations included: Review of the Medication Assistant's personnel record. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation,	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: KAITLIN PEITZ Title: Director of Operations Date: 04/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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:			
0252 SS= E	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure 1) food in the refrigerator was covered, 2) food was labeled upon placing in the refrigerator and 3) to discard expired food. Findings include: On 01/19/23 at 9:32 AM, located in the refrigerator was a large plastic bin containing vegetable pits. The bin was not labeled nor was it covered. In addition, there was a metal bin with food located inside of the bin. The label on the bin documented a preparation date of November 17, 2022 and a discard date of November 21, 2022. On 01/19/23 at 9:35 AM, the Dining Services Director confirmed the bin containing vegetables was not labeled and was not covered. The Dining Services Director confirmed a bin with a preparation date of November 17, 2022 and a discard date of November 21, 2022. The Dining Services Director explained all food is required to be accurately labeled upon opening and placing in the refrigerator, all food had to be covered and expired food items were to be discarded three days after the preparation date. Severity: 2 Scope: 2	0252	The Dining Services Director will review all food in the walk-in and reach-in fridges daily to ensure everything is dated and labeled. The Dining Services Director will assign one cook per evening to spot check all labeling and expired food nightly.	02/10/2023

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0451 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure expired medications were not stored in a first aid kit. Findings include: On 01/19/23 at 11:34 AM, the first aid kit located in the medication room in the memory care unit contained 11 0.03-ounce antibiotic ointment packets expired 09/2022. On 01/19/23 at 11:34 AM, the Maintenance Worker verbalized the ointment was expired. Severity: 2 Scope: 1	0451	The Wellness Director will complete inventory on all first aid kits monthly. Expiration dates will be written in big black letters. This will be an audit done every 4-6 weeks moving forward.	02/10/2023
0620 SS= F	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 16 of 16 residents receiving skilled nursing services (Resident #3, #5, #12, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27). Findings include: On 01/19/23 at 10:15 AM, the Administrator verbalized the facility had	0620	1. The Wellness Director will have all residents on home health and hospice on a waiver by March 10th. Residents #12, 17, 21, and 26 have passed away since the survey inspection. 2. Any resident that is put on home health or hospice will automatically have a care plan update and a waiver submitted. The waiver will be placed in the resident's medical chart. 3. The Wellness Director and Wellness Assistant to will audit for compliancy weekly. This audit will be added to the Quality Assurance checklist. 4. This will be the responsibility of the Wellness Director and Administrator	03/10/2023

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	residents receiving 24 hour skilled nursing care through home health and hospice agencies. The Administrator explained the Administrator was not aware of the requirement to submit waivers to the State Agency for residents receiving 24 hour skilled nursing care. The Administrator confirmed the facility had not submitted waivers to the State Agency to retain residents receiving 24 hour skilled nursing care. Resident #3 Resident #3 was admitted to the facility on 02/17/17, with diagnoses including depressive disorder, chronic diastolic heart failure and chronic obstructive pulmonary disease. On 01/19/23 at 12:20 PM, the Wellness Director verbalized Resident #3 received 24 hour skilled nursing care from a home health agency. The Wellness Director confirmed the most recent home health certification date was 09/15/22. Resident #5 Resident #5 was admitted to the facility on 07/15/22, with a diagnosis of vascular dementia without behavioral disturbance. On 01/19/23 at 12:10 PM, the Wellness Director verbalized Resident #5 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 09/08/22. Resident #12 Resident #12 was admitted to the facility on 08/25/22, with a diagnosis of dementia without behavioral disturbance. On 01/19/23 at 12:26 PM, the Wellness Director verbalized Resident #12 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 12/08/22. Resident #15 Resident #15 was admitted to the facility on 11/17/22, with diagnoses including chronic obstructive pulmonary disorder (COPD) and end stage heart failure. On 01/19/23 at 12:23 PM, the Wellness Director verbalized Resident #15 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 12/28/22. Resident			

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	#16 Resident #16 was admitted to the facility on 12/12/22, with diagnoses including adult failure to thrive and COPD. On 01/19/23 at 12:12 PM, the Wellness Director verbalized Resident #16 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 11/02/22. Resident #17 Resident #17 was admitted to the facility on 09/11/17, with diagnoses including dementia with psychotic behaviors and cerebral atherosclerosis. On 01/19/23 at 12:12 PM, the Wellness Director verbalized Resident #17 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 11/09/22. Resident #18 Resident #18 was admitted to the facility on 06/13/19, with diagnoses including congestive heart failure and chronic kidney disease stage III. On 01/19/23 at 12:19 PM, the Wellness Director verbalized Resident #18 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 12/19/22. Resident #19 Resident #19 was admitted to the facility on 02/10/22, with diagnoses including adult failure to thrive and dysphagia. On 01/19/23 at 12:22 PM, the Wellness Director verbalized Resident #19 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 01/05/23. Resident #20 Resident #20 was admitted to the facility on 12/19/22, with diagnoses including dementia without behaviors and cerebral atherosclerosis. On 01/19/23 at 12:23 PM, the Wellness Director verbalized Resident #20 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 10/03/22. Resident #21 Resident #21 was admitted to the facility on 09/01/21, with diagnoses including Alzheimer's disease			

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	with late onset and dementia without behaviors. On 01/19/23 at 12:24 PM, the Wellness Director verbalized Resident #21 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 11/04/22. Resident #22 Resident #22 was admitted to the facility on 01/09/19, with a diagnosis of Parkinson's disease. On 01/19/23 at 12:25 PM, the Wellness Director verbalized Resident #22 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 08/28/22. Resident #23 Resident #23 was admitted to the facility on 12/15/22, with a diagnosis of Parkinson's disease. On 01/19/23 at 12:26 PM, the Wellness Director verbalized Resident #23 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 12/13/22. Resident #24 Resident #24 was admitted to the facility on 10/19/22, with a diagnosis of Alzheimer's disease. On 01/19/23 at 12:25 PM, the Wellness Director verbalized Resident #24 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 09/07/22. Resident #25 Resident #25 was admitted to the facility on 09/08/22, with diagnoses including Alzheimer's disease and dementia. On 01/19/23 at 12:27 PM, the Wellness Director verbalized Resident #25 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 05/27/22. Resident #26 Resident #26 was admitted to the facility on 07/19/22, with a diagnosis of Parkinson's disease. On 01/19/23 at 12:15 PM, the Wellness Director verbalized Resident #26 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was			

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	07/21/22. Resident #27 Resident #27 was admitted to the facility on 06/02/20, with a diagnosis of senile degeneration of brain. On 01/19/23 at 12:18 PM, the Wellness Director verbalized Resident #27 received 24 hour skilled nursing care from a hospice agency. The Wellness Director confirmed the most recent hospice certification date was 12/12/22. Severity: 2 Scope: 3			

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0920 SS= D	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, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 1 of 7 resident rooms with a resident who self-administered medication (Room A-4). Findings include: On 01/19/23 at 9:20 AM, two residents occupied Room A-4. One resident self-administered medication and one resident's medications were managed by the facility. The resident who self-administered medication stored the medication in an unlocked drawer in a dresser. On 01/19/23 at 9:20 AM, the Maintenance Worker confirmed the medications were not secured against access by the resident whose medications were managed by the facility. Severity: 2 Scope: 1	0920	1. The Wellness Director created a self-medication list of all residents and a room audit was completed for each of these residents on 2/17/23. 2. Room audits will be completed 2x per month to ensure all self-medicated residents are in compliance. 3. The attached audit form will be completed and given to the administrator. 4. The Wellness Director and Administrator will be responsible for ensuring compliance.	02/17/2023

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0936 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 02/17/17, with diagnosis including depressive disorder, chronic diastolic heart failure and chronic obstructive pulmonary disease. Resident #3's record documented a TB test given on 01/11/22 and read negative on 01/14/22. The resident's record lacked documented evidence of an annual TB test for 2023. On 01/19/23 at 11:51 AM, the Wellness Director confirmed Resident #3 did not have a completed annual TB test. Severity: 2 Scope: 1	0936	All resident TB tests are up to date effective 2/8/23. The Wellness Director has created a spreadsheet that will be reviewed monthly to ensure all resident TB tests are given in a timely manner.	02/08/2023
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	0938	1. All resident charts were audited for ADL assessments. The ADL Assessment for resident #10 was located in the resident's chart during this audit.	02/03/2023

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	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 record review and interview, the facility failed to ensure Activities of Daily Living (ADL) assessments were completed on admission for 1 of 15 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 06/01/21, with a diagnosis of short term memory loss. Resident #10's clinical record lacked documented evidence of an initial ADL assessment completed on or prior to admission. On 01/19/23 at 12:05 PM, the Administrator verbalized the ADL assessments were required to be completed upon a resident's admission to the facility and annually thereafter. The Administrator confirmed Resident #10 did not have an ADL assessment completed on or prior to admission. Severity: 2 Scope: 1		2. All initial resident assessments will be reviewed by the Administrator prior to move-in. 3. The wellness director and administrator will review the initial ADL assessment prior to the resident’s move-in. Then each initial resident ADL assessment will be stored in the resident’s medical chart in a plastic sleeve. 4. The administrator and wellness director will be responsible for ensuring the ADL assessment is completed and filed correctly. 5. The audit was completed on 2/3/23. All new ADL assessments were reviewed by the administrator and wellness director on 2/6/23. 6. Audit has been attached. 7. Chart audits will be completed quarterly by the wellness director and administrator to ensure resident charts are organized and contain all necessary information.	

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0999 SS= E	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents housed in the memory care unit for 3 of 15 rooms occupied by a resident. Findings include: On 01/19/23 at 9:49 AM, the following toxic items were unsecured in Room D-14: - A one-ounce container of hemp seed hand and body lotion - A one-ounce container of Dr. Scholls original foot powder - A one-ounce container of Valley eye care ultra clarity spray lens cleaner - A 0.65-ounce container of MK Men advanced eye cream - A two-ounce container of True original cologne - A 28-ounce container of Suave Men 2-in-1 shampoo/conditioner On 01/19/23 at 9:52 AM, the following toxic items were unsecured in Room D-10: - A 0.21-ounce container of Colormates compact makeup. On 01/19/23 at 10:00 AM, the following toxic items were unsecured in Room D-8: - A 1.75-ounce container of Eucerin Aquaphor Healing ointment - An eight-tablet container of Dramamine motion sickness relief (expired 04/21) On 01/19/23 at 11:04 AM, the Administrator verbalized the facility lacked a policy which regulated toxic substances in the secured unit of the facility. On 01/19/23 at 9:49 AM through 10:00 AM, the Maintenance Worker confirmed the presence of unsecured toxic substances in rooms D-8, D-10, and D14. Severity: 2 Scope: 2	0999	The Wellness Direct and Wellness Team will be doing weekly sweeps of memory care for hazardous items. These sweeps will be documented and kept in the Quality Assurance Binder. A notice will be placed on the memory care doors, notifying visitors that all supplies must be approved by the Wellness Team prior to giving anything to the resident.	02/10/2023

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CARSON VALLEY SENIOR LIVING	**1189 KIMMERLING RD, GARDNERVILLE, NEVADA ,89460**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
1305 SS= C	Discrimination prohibited Inspector Comments: Based on observation and interview, the facility failed to post a current nondiscrimination statement prominently in the facility. Findings include: On 01/19/23 at 10:55 AM, the facility lacked a current nondiscrimination statement for residents and the public to view. On 01/19/23 at 10:55 AM, the Maintenance Worker acknowledged a nondiscrimination statement was not posted prominently in the facility. Severity: 1 Scope: 3	1305	1. The discrimination statement has been placed next to the activity calendar for easy viewing and accessibility. This was completed on 2/1/23. 2. The administrator will educate the team to know that the non-discrimination policy is next to the activity calendar in the main hallway. 3. The administrator will ensure the sign is visible weekly. 4. This is the administrator's responsibility.	02/01/2023
1310 SS= C	Discrimination prohibited Inspector Comments: Based on observation and interview, the facility failed to post prominently in the facility the State contact information to file a complaint for a resident who may have experienced prohibited discrimination. Findings include: On 01/19/23 at 10:55 AM, the facility lacked posted documentation of the State contact information to file a complaint for any resident who may experience discrimination. On 01/19/23 at 10:55 AM,, the Maintenance Worker acknowledged the State's contact information had not been posted in any common public area of the facility to inform residents where to file a complaint of discrimination. Severity: 1 Scope: 3	1310	1. The discrimination statement has been placed next to the activity calendar for easy viewing and accessibility. This was completed on 2/1/23. 2. The administrator will educate the team to know that the non-discrimination policy is next to the activity calendar in the main hallway. 3. The administrator will ensure the sign is visible weekly. 4. This is the administrator's responsibility.	02/01/2023
1540 SS= F	Cultural Competency Training Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 7 of 10 sampled employees required to obtain cultural competency training (Employees #3, #5, #6, #7, #8, #9, and #10). Findings include: On 01/19/23, the Corporate Executive Director was provided the Personnel Check List to complete for 10 sampled employees. The Corporate Executive Director provided the completed form with the following information:	1540	1.The Director of Operations will be auditing the team member files by 2/28. Employees #5, 6, 7, 8, and 9 are all signed up for the March 31st class. Employee #10 had the cultural competency training completed on 8/2022 and it is attached. 2. The team member files will be audited by the administrative assistant monthly to ensure all initial and annual training is completed. 3. The monthly audit will be turned into the administrator who will then assist in coordinating the required training with all department leaders. 4. The administrative assistant and	02/28/2023

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 _____	**01/19/2023**

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	Employee #3 Employee #3 was hired as Resident Assistant with a start date of 10/31/22. The personnel record for Employee #3 lacked a cultural competency training certificate, 20 days after the required 30 days. Employee #5 Employee #5 was hired as Resident Assistant with a start date of 12/10/22. The personnel record for Employee #5 lacked a cultural competency training certificate, 10 days after the required 30 days. Employee #6 Employee #6 was hired as Resident Assistant with a start date of 11/11/20. The personnel record for Employee #6 lacked a cultural competency training certificate, 202 days after training was required. Employee #7 Employee #7 was hired as Resident Assistant with a start date of 09/29/22. The personnel record for Employee #7 lacked a cultural competency training certificate, 82 days after the required 30 days. Employee #8 Employee #8 was hired as Medication Assistant with a start date of 12/05/22. The personnel record for Employee #8 lacked a cultural competency training certificate, 15 days after the required 30 days. Employee #9 Employee #9 was hired as Medication Assistant with a start date of 01/15/21. The personnel record for Employee #9 lacked a cultural competency training certificate, 202 days after training was required. Employee #10 Employee #10 was hired as Wellness Assistant with a start date of 08/18/21. The personnel record for Employee #10 contained a cultural competency training certificate dated 08/18/22, 48 days after training was required. On 01/19/23 at 1:45 PM, the Administrator provided the Attestation of Compliance form, signed and dated 01/19/23, confirming the Corporate Executive Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3		administrator are responsible for ensuring compliance.	
1700	Annual Assessment of History of Each	1700	1. The Wellness Director will be utilizing the	02/28/202

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SS= E	Resident Inspector Comments: Based on record review and interview, the facility failed to obtain annual Standard Physician Assessment and Placement Determination for 6 of 15 residents (Resident #8, #11, #13, #14, #3 and #9). Findings include: Resident #8 Resident #8 was admitted to the facility on 05/10/21, with diagnoses including dementia, chronic obstructive pulmonary disease, chronic kidney disease and hypertension. Resident #8's record documented an initial Standard Physician Placement Determination completed on 05/04/21. Resident #8's record lacked documented evidence a Standard Physician Placement Determination was completed in 2022. Resident #11 Resident #11 was admitted to the facility on 11/16/18, with diagnoses including hypertension and glaucoma. Resident #11's record documented an annual Standard Physician Placement Determination completed on 12/10/21. Resident #11's record lacked documented evidence a Standard Physician Placement Determination was completed in 2022. Resident #13 Resident #13 was admitted to the facility on 11/04/19, with diagnoses including high cholesterol, high blood pressure and atrial fibrillation. Resident #13's record documented an annual Standard Physician Placement Determination completed on 11/06/20. Resident #13's record lacked documented evidence a Standard Physician Placement Determination was completed in 2022. Resident #14 Resident #14 was admitted to the facility on 02/05/21, with diagnoses including hypothyroidism, essential hypertension, depression, and dementia. Resident #14's record documented an initial Standard Physician Assessment and Placement Determination completed on 01/26/21. Resident #14's record lacked documented evidence a Standard Physician Assessment and Placement Determination was completed in 2022. Resident #3		Standard Cognition form supplied by the State Surveyors. The physician assessment and physician placement determination will be completed on the identified residents. This has been done effective 2/28/23. 2. Prior to Admission and Annually the Physician Assessment and Placement Determination form will be completed along with the resident's physical. 3. To ensure compliance, the Physcian Assessment and Placement Determination will be audited monthly. The Standard Cognition form will be completed quaterly with the resident's care plan. 4. This will be the Wellness Director and Administrator's responsibility.	3

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	Resident #3 was admitted to the facility on 02/17/17, with diagnoses including depressive disorder, chronic diastolic heart failure and chronic obstructive pulmonary disease. Resident #3's record documented an initial Standard Physician Placement Determination completed on 02/27/20. Resident #3's record lacked documented evidence a Standard Physician Placement Determination was completed in 2022. Resident #9 Resident #9 was admitted to the facility on 05/25/21, with diagnoses including major depressive disorder and hypothyroid . Resident #9's record documented an initial Standard Physician Placement Determination completed on 05/18/21. Resident #9's record lacked documented evidence a Standard Physician Placement Determination was completed in 2022. On 01/19/23 at 11:05 AM, the Administrator verbalized Standard Physician Placement Determinations were updated annually. On 01/19/23 at 11:52 AM, the Wellness Director verbalized Standard Physician Placement Determinations were completed upon admission; however the Standard Physician Placement Determinations were not completed annually. Severity: 2 Scope: 2			