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 _____	**05/11/2023**

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 regrading survey conducted at your facility on 05/11/23, 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 74. Nine resident records and six employee records were reviewed. The facility received a grade of C. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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		
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	0252	-All food is covered, labeled and dated. -labels, date stickers -Daily audit	05/12/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: TRINA M ANDERSON Title: Administrator Date: 08/13/2023

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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	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 food in the reach in refrigerator was covered, food was labeled with a preparation and use by date upon placing in the refrigerator, and expired food was discarded. Findings include: On 5/11/23 at 12:50 PM, the following items were discovered in the reach in refrigerator: -a large metal container of uncovered and unlabeled raw hamburger patties located on the bottom shelf in the reach in refrigerator. -a plastic container of cooked beans with hamburger, labeled with a preparation date of 05/06. The label lacked the use by date. The cooked beans were located on the bottom shelf with the uncovered raw hamburger patties. -a large plastic container of cooked rice and a large plastic container of cooked chicken piccata, both labeled with a preparation date of 05/09 and a use by date of 05/15. The chicken picatta and rice was located on the bottom shelf with the uncovered raw hamburger patties. -a metal container of ketchup labeled use by 04/05. -a plastic container of olives labeled with a preparation date of 04/24. -a large plastic container of corned beef labeled use by 05/09. -a large plastic container of cranberry sauce labeled use by 05/08. On 05/11/23 at 12:51 PM, the Cook verbalized all food in the refrigerator should be covered and labeled with a preparation and use by date. Food should be discarded by the use by date on the label. The Cook verbalized the raw hamburger patties were uncovered and unlabeled and confirmed they should have been covered and labeled when put into the refrigerator. The Cook verbalized the cooked food should not be stored with raw foods and confirmed the containers of chicken picatta, rice, and beans should have not been stored on the		-Dining Services Director -05/12/23 -Audit Sheet Uploaded	

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	bottom shelf with raw meat. The Cook confirmed the cooked beans and olives lacked a use by date, and the ketchup, corned beef, and cranberry sauce lacked a preparation date. The Cook explained the dates on the cooked beans, ketchup, olives, corned beef, and cranberry sauce were the dates the food was opened or prepared. The Cook was unable to explain how other kitchen staff would know when food was opened, prepared, and when it needed to be discarded, without proper labeling. The Cook verbalized the ketchup could be stored and used for a couple of months because it was a condiment, the cranberry sauce and olives could be stored and used for a couple of weeks because it was a canned food item, and the cooked food could be stored for about a week. The Cook was unaware of the facility policy and storage guidelines for refrigerated foods. The Cook confirmed the cooked beans, ketchup, corned beef, and cranberry sauce should have been discarded based on the preparation and use by dates on the food storage containers. The facility policy titled "Food and Supply Storage Procedures," dated 04/13/23, documented all food items should be stored in a manner to prevent contamination and maintain the safety of the food for human consumption. Cover, label, and dated unused portions and open packages. Separate cooked and raw foods. Store cooked food above raw food. Date items, discard food past the use by or expiration date. Raw ingredients must be stored below cooked foods. The Food Storage Chart documented unused portions of food prepared on site that were reheated for service, such as rice, vegetables, soups, gravies, and meat sauces could be stored for three days. Severity: 2 Scope:3			

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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.	0451	-All new hires will be trained in 1st Aid & CPR within 30 days of hire. -Training Tracker -Monthly Certification Audit -Business Office Manager -All staff will be trained and certified in 1st Aid & CPR by 7/1/23	07/01/2023
0620 SS= E	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 clinical 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 3 of 9 sampled residents (Resident #5, #7, and #8). Findings include: Resident #5 Resident #5 was admitted to the facility on 02/17/17, with diagnoses including pulmonary hypertension, dyspnea, and insomnia. Resident #5's Episode Summary Report documented the resident was recertified for skilled nursing services through a home health agency on 01/02/23. Resident #5's clinical record lacked documented evidence an exemption request to retain a resident receiving skilled nursing services was approved. On 05/11/23 at 3:04 PM, the Health and Wellness Director verbalized Resident #5 received skilled nursing care from a home health agency and the most recent home health certification date was	0620	1) RCD will submit an exemption for the residents listed. See attached exemptions. 2) All residents that live at the community who are bedfast, require restraint (bed rails) will have an application for an exemption submitted to the state for approval in order for the resident to remain living at community. The approval letter will be filed in residents chart and file. 3) The corrective action will be monitored by the RCD and Executive Director routinely following the residents with change of conditions such, bedfast, restraints etc. and an exemption will be submitted. 4) Resident Care Director will be responsible 5) 8/13/23	08/13/2023

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	01/02/23. The Health and Wellness Director confirmed the facility did not have an approved exemption for Resident #5. Resident #7 Resident #7 was admitted to the facility on 10/27/22, with a diagnosis of vascular dementia. Resident #7's Hospice Comprehensive Assessment and Plan of Care Update documented the resident was certified for skilled nursing services through a hospice agency on 05/09/23. Resident #7's clinical record lacked documented evidence an exemption request to retain a resident receiving skilled nursing services was approved. On 05/11/23 at 3:05 PM, the Health and Wellness Director verbalized Resident #7 received skilled nursing care from a hospice agency and had a hospice certification date of 05/09/23. The Health and Wellness Director confirmed the Health and Wellness Director had not submitted an exemption request to the State Agency for Resident #7. Resident #8 Resident #8 was admitted to the facility on 06/27/22, with a diagnosis of vascular dementia. Resident #8's Hospice Comprehensive Assessment and Plan of Care Update documented the resident was certified for skilled nursing services through a hospice agency on 05/09/23. Resident #8's clinical record lacked documented evidence an exemption request to retain a resident receiving skilled nursing services was approved. On 05/11/23 at 3:06 PM, the Health and Wellness Director verbalized Resident #8 received skilled nursing care from a hospice agency and had a hospice certification date of 05/09/23. The Health and Wellness Director confirmed the Health and Wellness Director had not submitted an exemption request to the State Agency for Resident #8. Severity: 1 Scope: 2			

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0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to ensure the Administrator's license was posted in a conspicuous place for residents, staff, and visitors to review. Findings include: On 05/11/23 at 12:45 PM, upon entry into the facility, the Receptionist explained the previous Administrator left in January 2023 and an Administrator in Training (AIT) took over the Administrator position in March 2023. The Receptionist verbalized the Receptionist would go get the AIT to speak with the survey team. On 05/11/23 at 1:03 PM, the Administrator's license from the Board of Examiners for Long Term Care Administrators (BELTCA) was not displayed. On 05/11/23 at 2:51 PM, the Business Office Manager (BOM) introduced themselves to the survey team as the AIT. The BOM explained being employed with the facility since March 1, 2023, however, was still working toward a license to become Administrator and was in fact not the Administrator. Further, there was an individual from Corporate acting as the Administrator. The BOM explained no application for Administrator was submitted to the State and confirmed the facility did not have an Administrator BELTCA license posted. Severity: 1 Scope: 3	0644	-License posted in the facilty at all times. -Timely posting of license. -Monthly Visual audit of license posted. -Business Office Manager -6/8/23 -Copy of License uploaded	06/08/2023

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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.	0920	-All Medications have been placed & are kept in a locked box at alltimes. -Lock boxes in all resident units. -Montly unit audit of all lock boxes . -Director of Wellness -05/15/23 -Lock Box Audit uploaded.	05/15/2023

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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 9 sampled residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 02/27/23, with diagnosis including dementia, chronic atrial fibrillation and nonrheumatic mitral (valve) insufficiency. Resident #2's clinical record documented an admission first step TB test given on 02/13/23 and read negative on 02/16/23, and a second-step TB test given on 02/27/23 and read negative on 03/02/23. Resident #2's TB testing lacked evidence of the times given and the times read. On 05/11/23 at 3:22 PM, the Wellness Director confirmed the TB test for Resident #2 did not document times of administration or times read. The Wellness Director explained TB tests were required for all residents upon admission and annually thereafter and confirmed the times needed to be on the TB test to confirm the test was accurate within the 48 to 72 hour timeframe. Severity: 2 Scope: 1	0936	-All residents will have completed TB 06/09/23 testing prior to move in and annually. -Electronic system record. -Monthly electronic system audit. -Director of Wellness -06/09/23 -TB audit report uploaded.	06/09/2023
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents	0938	-All resident assessments will be completed prior to move in .	06/30/2023

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	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 clinical record review and interview, the facility failed to ensure Activities of Daily Living (ADL) Assessments were completed upon admission and annually for 2 of 9 sampled residents (Resident #2 and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 02/27/23, with diagnoses including dementia, chronic atrial fibrillation and nonrheumatic mitral (valve) insufficiency. Resident #2's clinical record documented an initial ADL Assessment dated 03/01/23, two days late. Resident #3 Resident #3 was admitted to the facility on 11/29/21, with diagnoses including neurocognitive disorder, benign essential hypertension and macrocytosis-no anemia. Resident #3's clinical record documented an initial ADL Assessment dated 11/24/21. The resident's clinical record lacked documented evidence an ADL assessment had been completed for 2022. On 05/11/23 at 3:22 PM, the Wellness Director confirmed		-Electronic service plan implementation. -Montly audit of electronic service plan system. -Director of Wellness -6/30/23 -Electronic System report uploaded.	

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	Resident #1, #2 and #3 did not have ADL Assessments completed timely and explained all residents were required to have an ADL Assessment completed upon admission and annually thereafter. Severity: 2 Scope: 1			
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.	0999	- All toxic substances have been removed. -All substances to be in locked cabinets or janitorial closets. -Daily Audit placed on task sheet for all staff in Memory Care. -Director of Wellness -06/16/23 -Task sheet uploaded	06/16/2023

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1305 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status.	1305	-Anti Discrimination policy posted -Annual update of policy posting -Visual audit -Monthly visual audit -Business Office Manager -06/12/23 -Picture of posting uploaded.	06/12/2023

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1310 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. (Added to NRS by 2019, 1333, effective January 1, 2020)	1310	-Anti Discrimination policy posted -Annual update of policy posting -Visual audit -Business Office Manager -06/12/23 -Picture of posting uploaded	06/12/2023

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 _____	**05/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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1540 SS= E	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103.	1540	-All staff will complete Culture of Competency Training within 30 days of hire. -Monthly Class scheduled for all new hires. -Monthly audit of certification tracker. -Business Office Manger -06/30/23 -Email confirmation and invoices uploaded.	06/30/2023
1700 SS= A	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical	1700	1) Physical and Determination of placement was completed three days after POC. 2) A tracker will be put into place for all residents; including physical and determination of placement. 3) If there is a change of condition prior to the annual physical and determination is due, a new physical and determination of placement will be completed immediately and placed in the residents chart. 4) Administrator or designee such as Resident Care Director will be responsible 5) 6/30/23	06/30/2023

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	examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the facility failed to ensure a Placement Determination was completed timely per their Plan of Correction (POC) for 1 of 9 sampled residents (Resident #7). Resident #7 Resident #7 was admitted to the facility on 10/27/22, with a diagnosis of vascular dementia. Resident #7's Placement Determination was dated 03/03/23, three days after the facility's POC compliance date of 02/28/23. On 05/11/23 at 3:04 PM, the Health and Wellness Director confirmed Resident #7's Placement Determination was completed after the POC compliance date of 02/28/23. Severity: 1 Scope: 1			

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0050 SS= E	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 observation, record review, document review, and interview, the facility failed to have an approved Administrator to provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAG Y0040, Y0252, Y0620, Y0644, Y0936, Y0938, Y1540 and Y1700 Severity: 2 Scope: 3	0050	-Licesned and approved Administrator on file. -Timely hiring of Administrator or Licensee . -Timely hiring of Administrator. -Regional Director of Operations. -6/2/23 -Copy of License uploaded.	06/02/2023