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 _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLANTE OF RENO	**222 EAST PATRIOT BLVD, RENO, NEVADA ,89511**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure grading resurvey and a complaint investigation conducted at your facility on 10/10/2024 and completed on 10/29/2024. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 134 Residential Facility for Group beds, which provides assisted living services for elderly or disabled persons, 57 Category I, 45 Category II (non-Alzheimer's) residents and/or persons with Alzheimer's disease, 32 Category II Alzheimer's residents. The census at the time of the survey was 101. Twenty-three resident files were reviewed, and nine employee files were reviewed. The facility received a grade of D. Your facility has received a C or D grade for this inspection. 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 were five complaints investigated. Complaint #NV00070679 with an allegation of insufficient staff in the memory care unit was substantiated (see Tag Y0966). Complaint #NV00070853 with an allegation a resident was not receiving medications as ordered by the physician was substantiated (See tag Y878). The following allegations could not be substantiated due to a lack of evidence. Allegation #2: A resident was	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: TIMOTHY M GRAFTON | Title: Executive Director | Date: 12/30/2024

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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	neglected by the facility due to having scabies. Allegation #3: A resident was not receiving bathing assistance. The investigation into the allegation included: Observations of staff to resident interactions, call lights being answered, and resident hygiene/grooming. Interviews were conducted with two residents, a caregiver, two medication technicians and the Administrator. Review of 18 resident files, including the residents of concern, included review of Medication Administration Records (MAR) and Physician orders. Review of nine employee files included, elder abuse training, caregiver training, and medication management training. Review of the facility policy for Resident Rights, Activities of Daily Living (ADL), Medication Administration and Abuse, Neglect and Exploitation. Complaint #NV00071971 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: The facility inadequately charged a resident for services provided, and did not provide a refund for those services. Allegation #2: The facility failed to notify a resident of a change in their Plan of Care. Allegation #3: The facility confiscated and administered a Resident's medications without consent, or an Ultimate User agreement in place. Allegation #4: The facility failed to provide a resident's representative with resident records upon request. The investigation into the allegations included: Observations of staff to resident interactions, business office operations, and medication administration to resident's. Interviews were conducted with one resident, and the Administrator. Review of 18 resident files, including the residents of concern, included review of MARs and Physician orders. Review of nine employee files included, elder abuse training, caregiver training, and medication management training. Review of the facility policy for Resident Rights, refund policy, Level of Care Policy, Medication Administration, and Abuse, Neglect and			

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	Exploitation. Complaint #NV00072341 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: The facility failed to provide services indicated within a resident's plan of care per physician orders. Allegation #2: The facility failed to properly manage and administer resident medications. Allegation #3: The facility failed to provide Quality of Care for a resident. Allegation #4: The facility failed to maintain a clean environment for a resident. Allegation #5: The facility failed to monitor and maintain resident medications, resulting in resident neglect. The investigation into the allegations included: Observations of staff to resident interactions, and resident hygiene/grooming, resident bathrooms and living areas, kitchen staff serving lunch meals, and medication administration to residents. Interviews were conducted with two residents, a caregiver, one medication technician, and the Administrator. Review of 23 resident files, including the residents of concern, included review of MARs and Physician orders. Review of nine employee files included, elder abuse training, caregiver training, and medication management training. Review of the facility policy for Resident Rights, Activities of Daily Living, Medication Administration and Abuse, Neglect and Exploitation. Complaint #NV00072552 with an allegation a resident was not receiving medications at the time ordered per the physician was substantiated (See tags Y878 and Y895). The following allegations could not be substantiated due to a lack of evidence. Allegation #2: A resident without the capacity to consent was sexually abused by another resident and sustained serious injury. Allegation #3: A resident's family was not notified of alleged abuse. Allegation #4: The facility did not respond to filed grievances in a timely manner. Allegation #5: Rates for services were not disclosed. Allegation #6: Discontinued medications were administered. Allegation #7:			

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	Medications were administered at the incorrect dose. Allegation #8: Ordered medications were not administered. The investigation into the allegations included: Observations of staff to resident interactions, resident to resident interactions, posted service rates, and resident hygiene/grooming. Interviews were conducted with two residents, a medication technician, the Business Office Manager, the Wellness Director, and the Administrator. Review of five resident files, including the residents of concern, included review of diagnoses, physician notes, service plans, ultimate user agreements, legal representation, MARs, physician orders, physician placement determinations, and Saint Louis University Mental Status Examination (SLUMS) assessments. Review of facility documents including the Admission Contract and Resident Handbook. Review of the facility policy for Medication Assistance Procedures, General Medication Guidelines, Mobility and Fall Assessments, Incident Reporting, and Abuse, Neglect, and Exploitation. 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 investigation, 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:			
0053 SS= C	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate.	0053	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024
0074 SS= F	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide	0074	1) All staff had completed Elder Abuse Training and certificate placed in employee file as reviewed on previous surveys. These previously reviewed certificates did not include grades. Based on recent survey, Elder Abuse Training Certificates have been updated to include Grades.	12/30/2024

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	personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care		Each listed Employee reviewed for this recent survey have retaken abuse training and completed with Graded certificate. 2) New hire check list includes date of Elder Abuse Training completed with Completion Certificate which now includes Completed Grade. A review all of Staff Members will be completed for compliance. 3) Business Office Manager completes new hire checklist with new employee. Executive Director will review check list to ensure Elder Abuse Training certificate meets the State standard. 4) Business Officer Manager and Executive Director 5)12/30/2024	

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	to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that			

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	each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review, document review, and interview, the Administrator failed to ensure 8 of 10 sampled employees received initial elder abuse training prior to beginning work at the facility or received annual elder abuse prevention training, and employee competency was determined by a graded post test (Employee #7, #8, #9, #10, #11, #12, #13 and #14). Findings include: The facility's Plan of Correction dated 07/09/2024, documented the Executive Director and Business Office Manager (BOM) would ensure compliance with elder abuse training by the BOM would complete new hire checklist for required training and certifications within the regulation and a monthly review of employee files to ensure initial training and annual training completed and audited by BOM. The POC documented the correction date as 02/28/2024. The following employees had documented evidence of an ungraded Elder Abuse Training Test Questionnaire (Questionnaire) without the facility's review for competency and sign off: - Employee #7 was hired as a Resident Care Partner (RCP) with a start date of 05/22/2024. The employee's Questionnaire was dated 05/22/2024. - Employee #8 was hired as an RCP with a start date of 07/08/2024. The employee's Questionnaire was dated 07/08/2024. - Employee #9 was hired as an RCP with a start date of 09/16/2024. The employee's Questionnaire was dated 09/16/2024. - Employee #10 was hired as a Medication Technician (MT) with a start date of 04/09/2024. The employee's Questionnaire was dated 04/19/2024. The training was given 10 days late, after the			

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	employee started work with the residents. - Employee #11 was hired as an MT with a start date of 03/11/2024. The employee's Questionnaire was dated 03/14/2024. The training was given 3 days late, after the employee started work with the residents. - Employee #12 was hired as an MT with a start date of 05/28/2024. The employee's Questionnaire was dated 04/03/2024. - Employee #13 was hired as an MT with a start date of 07/30/2024. The employee's Questionnaire was dated 07/30/2024. - Employee #14 was hired as an RCP with a start date of 05/06/2024. The employee's Questionnaire was dated 05/06/2024. On 10/10/2024 1:15 PM, the BOM confirmed the aforementioned employees had participated in an elder abuse training class with the BOM then took a test. The BOM confirmed the test had not been graded by the BOM and the employees' competency of the elder abuse prevention training material had not been determined by grading the test. The facility policy titled "Abuse, Neglect and Exploitation," effective April 14, 2023, documented staff will receive training on elder abuse incidence, signs and symptoms, and reporting requirements. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 3			

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0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review and interview, the Administrator failed to maintain an accurate staffing schedule including all amended changes. Findings include: On 10/10/2024, review of the June 2024, July 2024, August 2024, September 2024 and October 2024, staffing schedules for the Memory Care Unit, lacked documented evidence of any amended changes to the schedule. On 10/10/2024 at 2:00 PM, the Administrator verbalized the schedules reflected the final version of the schedule and not the original schedule with amended changes. The Administrator confirmed there had been multiple changes to the aforementioned schedules. The Administrator verbalized the facility had recently changed to a new scheduling system program which would track any amended change to the schedule in the future. Severity: 1 Scope: 3	0088	1) Managers have been trained on new scheduling software which includes ability to show up to date schedule including before/after changes. 2)Department Managers will print weekly schedules which will reflect any staffing changes made that week 3) Completed weekly schedules will be printed and placed in schedul binder for Wellness Director and Executive Director Review. 4) Wellness Director, Memory Care Director, Executive Director 5)12/30/2024	12/30/2024
0160 SS= C	Advertising - NAC 449.205 Advertising and promotional materials. (NRS 449.0302) Advertising and promotional materials for a residential facility must be accurate and not misrepresent accommodations, services or programs offered by the facility.	0160	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024

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0450 SS= F	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on personnel file review, document review, and interview, the facility failed to ensure employees had cardiopulmonary resuscitation and first aid training which included skills testing for 6 of 10 employees (Employee #6, #8, #9, #10, #11, and #14. Findings include: The following employees had documented evidence of CPR and first aid training which did not meet the equivalent of the American Red Cross to include skills testing: - Employee #6 was hired as the Wellness Director with a start date of 05/22/2024. - Employee #8 was hired as a Resident Care Partner (RCP) with a start date of 07/08/2024. - Employee #9 was hired as an RCP with a start date of 09/16/2024. - Employee #10 was hired as a Medication Technician (MT) with a start date of 04/09/2024. - Employee #11 was hired as an MT with a start date of 03/11/2024. - Employee #14 was hired as an RCP with a start date of 05/06/2024. On 10/10/2024 at 1:15 PM, the Business Office Manager confirmed the aforementioned Employees lacked CPR and first aid training which included skills testing. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 3	0450	1) All staff listed in survey had completed CPR and certificate placed in employee file as reviewed on previous surveys. Based on recent survey, CPR certificates did not include in person completion. Each listed Employee reviewed for this recent survey will retake CPR. Employee #10 is no longer employed with facility as of 12/11/24. 2) New hire check list includes date of approved CPR completed. A review all of Staff Members will be completed for compliance. 3) Business Office Manager completes new hire checklist with new employee. Executive Director will review check list to ensure CPR Training certificate meets the State standard. 4) Business Office Manager and Executive Director 5)12/30/2024	12/30/2024
0520 SS= D	Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 2. A person-centered service plan developed pursuant to this section	0520	1) Hospice company contacted day of survey. Hospice nurse returned to community same day with required binder.Normal protocol is for Hospice RN to complete their assessment and care plan	12/30/2024

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	must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (e) Permission for the resident to rest in his or her room at any time; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on clinical record review, document review and interview, the facility failed to ensure a person-centered service plan was updated to address the resident's hospice care when admitted to hospice care services for 1 of 23 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 03/31/23, with a diagnosis of legally blind. On 10/10/24, Resident #2's person-centered service plan dated 09/19/2024, lacked documented		and leave either facility with the binder, or as in this case, leave binder with the independent resident. A review of all current residents receiving hospice care will be reviewed for compliance. 2) In the future, all new hospice personnel will be required to check in with the front desk before leaving facility where Wellness Director or designee will review hospice care plans, assessments, and Binder. 3) Hospice binders will be reviewed by Wellness Director or Memory care director weekly or if care plan has changed. 4) WEllness Director, Memory Care Director 5) 12/30/2024	

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	evidence of hospice care services and coordination with the hospice service agency. On 10/10/2024 at 4:11 PM, the Administrator verbalized Resident #10 had been admitted to hospice services on 09/13/2024 and confirmed Resident #10's person-centered service plan dated 09/19/2024 lacked hospice care services. The Administrator verbalized the resident's service plan should be updated with a significant change. The facility policy titled "Service Plans," effective 04/14/23, documented service plans were completed or reviewed/updated upon change of significant change of condition. Severity: 2 Scope: 1			
0556 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on interview and document review, the facility failed to ensure abuse of a resident was reported to the Aging and Disability Services Division (ADSD) or law enforcement within 24 hours of the abuse for 1 of 23 sampled residents (Resident #21). Findings include: Resident #21 Resident #21 was admitted to the facility on 04/27/2022, with diagnoses including hyperlipidemia and atrial fibrillation. On 10/29/2024 at 10:52 AM, the Wellness Director verbalized a visitor had pushed Resident #21 in the facility's dining room on 10/25/2024. The push caused Resident #21 to stumble backward and fall onto the seat of the resident's walker. The Wellness Director verbalized the incident occurred at dinner time and several residents were present in the dining room	0556	1) Staff will be in-serviced regarding reporting of abuse with emphasis on making report regardless if resident would like to report or not. Staff will make report and then resident can then inform reported agency of their desire for next steps or not. 2)Continue with abuse reporting training classes with specific emphasis on resident wishes. 3)Wellness director to provide periodic checks regarding abuse reporting knowledge of staff 4) Wellness Director 5) 12/30/2024	12/30/2024

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	and witnessed the visitor push Resident #21. One staff member, a Medication Technician (Med Tech), witnessed the incident. The Wellness Director explained the Wellness Director was notified in the evening of 10/25/2024, of Resident #21 being pushed by a visitor. The Wellness Director reported the incident to the State Ombudsman the morning of 10/28/2024. Staff offered to report the incident to police however a report was not made as Resident #21 did not want to pursue charges against the visitor. On 10/29/2024 at 1:22 PM, Resident #21 recalled a visitor "went crazy" on the resident sometime in the past week. Resident #21 elaborated to say the visitor screamed at the resident in the dining room. Resident #21 verbalized Resident #21 was embarrassed and "pissed off" about being screamed at in the dining room in front of other residents. The resident recalled the resident was asked by staff if the resident wanted to submit a police report and the resident declined. On 10/29/2024 at 3:43 PM, a Med Tech verbalized the Med Tech had received training related to abuse upon hire. The Med Tech explained abuse included physical and verbal abuse. The Med Tech verbalized screaming at a resident would be an example of verbal abuse. On 10/29/2024 at 5:39 PM, the Administrator verbalized abuse included physical and verbal abuse. The Administrator explained the visitor screaming at and pushing Resident #21 in the dining room on 10/25/2024 was considered abuse. The Administrator verbalized the Administrator was required to report suspicion or allegations of abuse to the Administrator's supervisor, state officials, and Adult Protective Services within 24 hours of becoming aware of the suspicion or allegation. The Administrator recalled the Administrator was notified on 10/25/2024 by a Med Tech, of Resident #21 being pushed in the dining room by a visitor. The Administrator verbalized the incident was reported to the State			

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	Ombudsman on the morning of 10/28/2024. The Administrator confirmed the Administrator had not reported the abuse of Resident #21 to any outside agencies, including ADSD or law enforcement within the required 24-hour timeframe. The Administrator denied the Administrator had any documented evidence the incident was reported to any outside agencies by any other member of the facility's staff within the required 24-hour timeframe. The facility policy titled "Abuse, Neglect, and Exploitation," effective 04/14/2023, documented any suspected incidence of abuse was to be reported and the supervisor or Administrator was to be notified immediately. If suspected abuse was substantiated, a written report was to be made to appropriate licensing/regulatory agencies as required by the State Agency. The facility policy titled "Incident Reports," effective 04/14/2023, documented the Administrator was responsible to have knowledge of required reporting in accordance with regulatory or local code in a timely manner. Events required to be reported included abuse. Severity: 2 Scope: 1			
0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or	0557	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024
0590 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another	0590	1) All Management Staff will be in-serviced regrading reporting of abuse with emphasis on making report regardless if resident would like to report or not. Staff will make report and then resident can then inform reported agency of their desire for next steps or not. Incident to be reviewed by Executive Director in the appropriate time allowed.	12/30/2024

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	resident of the facility or any person who is visiting the facility; Inspector Comments: Based on interview and document review, the Administrator failed to ensure a resident was kept safe from verbal and physical abuse by a visitor for 1 of 23 sampled residents (Resident #21). Findings include: Resident #21 Resident #21 was admitted to the facility on 04/27/2022, with diagnoses including hyperlipidemia and atrial fibrillation. On 10/29/2024 at 10:52 AM, the Wellness Director verbalized a visitor had pushed Resident #21 in the facility's dining room on 10/25/2024. The push caused Resident #21 to stumble backward and fall onto the seat of the resident's walker. The Wellness Director verbalized the incident occurred at dinner time and several residents were present in the dining room and witnessed the visitor push Resident #21. One staff member, a Medication Technician (Med Tech), witnessed the incident. The Wellness Director explained the Wellness Director was notified in the evening of 10/25/2024, of Resident #21 being pushed by a visitor. The Wellness Director reported the incident to the State Ombudsman the morning of 10/28/2024. Staff offered to report the incident to police however a report was not made as Resident #21 did not want to pursue charges against the visitor. On 10/29/2024 at 1:22 PM, Resident #21 recalled a visitor "went crazy" on the resident sometime in the past week. Resident #21 elaborated to say the visitor screamed at the resident in the dining room. Resident #21 verbalized Resident #21 was embarrassed and "pissed off" about being screamed at in the dining room in front of other residents. The resident recalled the resident was asked by staff if the resident wanted to submit a police report and the resident declined. On 10/29/2024 at 3:43 PM, a Med Tech verbalized the Med Tech had received training related to abuse upon hire. The Med Tech explained abuse		2)Continue with abuse reporting training classes with specific emphasis on resident wishes. 3)Wellness director to provide periodic checks regarding abuse reporting knowledge of staff 4) Wellness Director 5) 12/30/2024	

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	included physical and verbal abuse. The Med Tech verbalized screaming at a resident would be an example verbal abuse. On 10/29/2024 at 5:39 PM, the Administrator verbalized abuse included physical and verbal abuse. The Administrator explained the visitor screaming at and pushing Resident #21 in the dining room on 10/25/2024 was considered abuse. The facility's document titled "Service Delivery Contract for Residential Facilities for Groups, - Exhibit C," undated, documented the Administrator was to ensure residents were not abused by facility staff members, other residents of the facility, or any person who was visiting the facility. The facility policy titled "Abuse, Neglect, and Exploitation," effective 04/14/2023, documented personnel were encouraged to report to the proper state agency or law enforcement any activity, abuse or any other wrongdoing believed to pose a substantial risk to a resident's health, safety or welfare. Severity: 2 Scope: 1			
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure a physical examination including a review of systems was completed prior to admission or annually for 4 of 23 residents (Resident #3, #5, #15, and #7). Findings	0859	1) Utilize reporting function of Resident management system to be able to track annual due dates of specific requirements. A review of all current resdidents will be completed to ensure complaince this survey reporting window 2) Wellness Director and Memory Care director will review monthly upcoming annual due dates for following month. 3) Executive Director will review report of annual dates monthly 4)Wellness Director, Memory Care DIrector, Executive Director 5)12/30/2024	12/30/2024

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	include: Resident #3 Resident #3 was admitted to the facility on 03/29/2023, with diagnoses including hypertension, restless legs, and dyslipidemia. Resident #3's record documented an initial physical examination dated 03/24/2023 and an annual physical examination dated 07/18/2024. The annual physical examination was completed 117 days late. Resident #5 Resident #5 was admitted to the facility on 03/07/2022, with a diagnosis of dementia/memory loss. Resident #5's record documented a physical dated 03/13/2023 and an annual physical examination dated 07/18/2024. The annual physical examination was completed 128 days late. Resident #15 Resident #15 was admitted to the facility on 12/17/2016, with diagnoses including chronic kidney disease, allergic rhinitis, hypertension. Resident #15's record documented a physical dated 03/16/2023 and an annual physical examination dated 07/18/2024. The annual physical examination was completed 124 days late. Resident #7 Resident #7 was admitted to the facility on 04/30/2024, with diagnoses including dementia, iron deficiency and incontinence. Resident #7's record documented a physical dated 12/28/2023, however lacked a review of systems. On 10/10/2024 at 3:26 PM, the Administrator verbalized the history and physicals were to be completed prior to move in and annually there after. Annually was to be done within the 12 months of the previous history and physical. All history and physicals must include review of systems. The Administrator confirmed the Resident's #3, #5, and #15 history and physicals were completed late and Resident #7's history and physical lack a review of systems. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 1			

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0874 SS= D	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 clinical record review, document review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse, was reviewed and initialed by the Administrator within 72 hours for 1 of 23 residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 04/30/2024, with diagnoses including dementia, iron deficiency ad incontinence. Resident #7's clinical record documented a six month medication profile review dated 06/30/2024, lacked evidence of the Administrator's review and initials. On 10/10/2024 at 3:45 PM, the Administrator confirmed the Administrator had not initialed the medication profile review dated 06/30/2024 for Resident #7, and verbalized the Administrator needed to review and initial the report within 72 hours. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 1	0874	1) All medication orders have been reviewed for compliance this survey reporting window. All residents medications are pharmacy reviewed every 6 months per regulation. Medications that require a pharmcay /dr review outside of this timeline will be brought to Executive Directors aattention immidiately. 2)Executive Director will review any new medication that requires pharmacy /dr review as it is ordered. 3)Executive Director will review med changes as hey pertain to requiring a review by dr/pharmacy 4)Executive Director 5)12/30/2024	12/30/2024
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or	0878	1) Staff have been in-serviced as to next steps when facility is unable to obtain medication from either pharmacy or family. Staff are to immediately report to physician regarding medication availability and the follow physicians directives from there. 2)Weekly medication cart and MAR audits will be completed by Wellness director or	12/30/2024

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	advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph		designated staff. 3)Weekly audits and MAR alert settings related to med administration 4)Wellness Director, Memory Care Director, Executive Director 5)12/30/2024	

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	(b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, and record review the facility failed to ensure 1) residents' medications were administered as ordered by the physician for 2 of 23 sampled residents (Resident #16 and #20), 2) medications were available for 1 of 23 sampled residents (Resident #8). Findings include: Resident #16 Resident #16 was admitted to the facility on 06/09/2021, with diagnoses including chronic obstructive pulmonary disease, hyperlipidemia and scabies. Discharged on 05/31/2024. On 10/10/2024 review of Resident #16's March 2024 Medication Administration Record (MAR), documented Resident #16 did not received the following medications on 03/05/2024, 03/11/2024, 03/12/2024, 03/20/2024 as indicated with a dash on the MAR. -Amlodipine Besylate 5 milligram (mg) tablet, take one tablet by mouth in the morning for hypertension. -B complex capsule, take one capsule by mouth daily -Eucerin Cream, apply topically daily to affected areas as directed for dry skin. -Magnesium Oxide 420 mg tablet, take one tablet by mouth daily. -Permethrin 5% cream, apply a thin layer of cream daily, use as directed from neck to soles of feet, wash off after 8-14 hours to affected areas. -Pink bismuth chew tablet, take one tablet by mouth twice daily for diarrhea. -Spironolactone 25 mg tablet, take one tablet by mouth daily. -Terzosin 2 mg capsule, take one capsule by mouth in the morning. -Triamcinolone 0.1% cream, apply cream topically twice daily to affected areas for rash. -Vitamin B-12 5000 micrograms (mcg) tablet, take one tablet by mouth in the morning. On 10/10/2024 at 3:45 PM, a Medication Technician verbalized a dash on the MAR indicated no documentation if the resident received the medication or not. There were no other notes documented if the resident received the medication as prescribed by the physician, or if the			

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	resident was out of the facility. The Medication Technician confirmed the MAR should document if the medication was given as prescribed or not. Resident #20 Resident #20 was admitted to the facility on 11/25/2018, with a diagnosis of pure hypercholesterolemia. Discharged 10/25/2024. A physician's order dated 03/26/2024, documented Atorvastatin 40 mg tablet, take one tablet by mouth in the evening. On 10/29/2024, Resident #20's October 2024 MAR documented Atorvastatin 40 mg tablet take one tablet by mouth daily, was administered every day from 10/01/2024 to 10/25/2024, at 8:00 AM. On 10/29/2024 at 6:10 PM, the Administrator verbalized staff were expected to discuss and confirm with the pharmacy if the physician's order and resident MAR did not match. The Administrator confirmed the physician order documented Atorvastatin to be administered in the evening, and the MAR documented Atorvastatin was given in the morning at 8:00 AM from 10/01/2024 to 10/25/2024. The facility policy titled, "General Medication Guidelines," dated 04/14/2023, documented medication room audits would be performed periodically to assure medications listed on the MAR follow physician orders. Resident #8 Resident #8 was admitted to the facility on 08/21/2024, with diagnoses including hypertension, and generalized weakness. On 10/10/2024, during medication review, Resident #8's October 2024 MAR documented Milk of Magnesia 400 mg / 5 milliliters (ml) oral suspension take 30 ml by mouth every 24 hours as needed, was not available for administration. A physician's order dated 06/25/2024, documented Milk of Magnesia 400 mg / 5 ml oral suspension take 30 ml by mouth every 24 hours as needed. On 10/10/2024 at 2:28 PM, the Medication Technician confirmed Resident #8's Milk of Magnesia was not on site to be administered as needed and the facility would carry all hospice medications in the			

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

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	facility for the resident. Severity: 2 Scope: 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on record review, document review and interview, the Administrator failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 23 sampled residents (Resident #7 and #20). Findings include: Resident #7 Resident #7 was admitted to the facility on 04/30/2024, with diagnoses including dementia, iron deficiency and incontinence. During the medication review the following medications were not available, however were documented on the MAR. -Bisacodyl 10 milligram (mg) suppository, insert one suppository rectally daily as needed for constipation, if no results from Milk of Magnesia. -Senna 8.6	0895	1) Staff have been in-serviced as to next steps when facility is unable to obtain medication from either pharmacy or family. Staff are to immediately report to physician regarding medication availability and the follow physicians directives from there. 2)Weekly medication cart and MAR audits will be completed by Wellness director or designated staff. 3)Weekly audits and MAR alert settings related to med administration 4)Wellness Director, Memory Care Director, Executive Director 5)12/30/2024	12/30/2024

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	mg softgel, take one capsule by mouth daily as needed for constipation On 10/10/2024 at 1:02 PM, the Medication Technician confirmed Resident #7's MAR needed to be updated to reflect the current physician's orders. The Medication Technician verbalized the suppository and Senna softgel for Resident #7 were discontinued and the MAR was not updated. Resident #20 Resident #20 was admitted to the facility on 11/25/2018, with a diagnosis of pure hypercholesterolemia. Discharged 10/25/2024. A physician's order dated 03/26/2024, documented Atorvastatin 40 mg tablet, take one tablet by mouth in the evening. On 10/29/2024, Resident #20's October 2024 MAR documented Atorvastatin 40 mg tablet take one tablet by mouth daily, was scheduled for 8:00 AM. On 10/29/2024 at 6:10 PM, the Administrator verbalized staff were expected to discuss with the confirm with the pharmacy if the physician's order and resident MAR do not match. The Administrator confirmed the physician order documented Atorvastatin to be administered in the evening, and the MAR documented Atorvastatin was scheduled for 8:00 AM. The facility policy titled, "Medication Assistance Procedures," dated 04/14/2023, documented Resident MARs would be checked with the physician's orders to assure the proper administration of all medications. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 1			
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.	0920	1) Review of all medication completed for compliance. All meds labeled appropriately. Reminder Notice given to family and self administrating residents regarding the labeling and storage of medication. Addressed as well in Handbook. 2) Weekly medication cart and Mar audits for correct labels will be completed by Wellness director or designated staff. 3) Wellness Director to review completed weekly audits	12/30/2024

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	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 10 resident rooms with residents self-administering medication (Room #106). Findings include: The facility's Plan of Correction dated 07/09/2024, documented the Executive Director reiterated to attending residents at a Resident Counsel meeting of the requirement of those handling their own medication of the facility policy. Resident caregivers, Med techs and housekeepers were in-serviced regarding checking resident doors secured. Reminder to ensure medication were locked were entered in Newsletter. The POC documented the correction date as 02/28/2024. On 10/10/2024 at 9:44 AM, Resident Room #106 contained unsecured medications on a table, kitchen counter and an unlocked kitchen cabinet. The resident's room door was unlocked. On 10/10/2024 at 9:44 AM, the Resident #19 verbalized the resident did not lock their room door and confirmed the medications were not locked away. On 10/10/2024 at 9:48 AM, the Maintenance Director confirmed the medications were not secured and verbalized all medications should be secured. The Maintenance Director verbalized residents can lock their medications in a kitchen cabinet with a lock which was supplied by the facility or by		4) Wellness Director, Memory Care Director 5)12/30/2024	

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	locking their room door. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 1			

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, record review, and interview the facility failed to ensure the prescriber's name and the resident's name were documented on the label of an over-the-counter medication for 2 of 23 sampled residents (Resident #9, and #10). Findings include: Resident #9 Resident #9 was admitted to the facility on 06/05/2024, with diagnoses including cognitive communication deficit. On 10/10/2024 at 2:32 PM, during a review of Resident #9's medications, one container of Vitamin D3 2000 units softgel capsules was with Resident #9's medications. The container lacked the prescriber's name. On 10/10/2024 at 2:35 PM, the Medication Technician confirmed the prescriber's name was not documented on the container of Vitamin D3 softgel capsules. Resident #10 Resident #10 was admitted to the facility on 03/31/2024, with diagnoses including legally blind, cerebral atherosclerosis, and hypothyroid. On 10/10/2024 at 2:15 PM, during a review of Resident #10's medications, one container of GNP Ibuprofen 200 mg softgel capsules was with Resident #10's medications. The container lacked the prescriber's name and resident's name. On 10/10/2024 at 2:18 PM, the Medication Technician confirmed the prescriber's name and resident's name were not documented on the container of GNP Ibuprofen softgel capsules for Resident #10. Severity: 2 Scope: 1	0923	1) Review of all medication completed for compliance. All meds labled appropriaely. 2) Weekly medication cart and Mar audits for correct lables will be completed by Wellness director or designated staff. 3) Wellness Director to review compelted weekly audits 4) Wellness Director, Memory Care Director 5)12/30/2024	12/30/2024

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0966 SS= F	Alzheimer’s Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on interview and document review, the facility failed to ensure there was staffing of one caregiver for every assigned interaction group of not more than six residents in the memory care unit during residents' waking hours in an Alzheimer's endorsed facility. Findings include: Review of the June 2024, July 2024, August, 2024 and September 2024 staffing schedules documented the facility failed to provide a minimum of one caregiver for no more than six residents assigned interaction groups residing at the facility, which was endorsed for Alzheimer's Disease. The census was as follows: June 2024 -28 residents on June 17 through 24, -29 on June 25 through 30 July 2024 -27 on July 1 through 30, -26 on July 31 August 2024 - 27 on August 1 - 29 August 2 through 31 September 2024 - 27 on September 1 through 15, - 26 on September 16 through 18 - 27 on September 19 - 28 on September 20 - 29 on September 21 through 30 October 2024 - 29 on October 1 through 10 The census required five staff members from June 17 through October 10, 2024, during resident waking hours. On 10/10/2024, the facility lacked documented evidence of staff assignments on the staffing schedule for the aforementioned dates, defining the interaction groups in the memory care unit in the facility. The facility's staffing schedule did not meet the staffing requirement of one	0966	1) Staffing shortage has ben resolved immediately after time frame of this specific tag. 2) New scheduling system allows for staffing allows for managing appropriate number of staff for memory care 3) Scheduling software alert systems allow for proactive measures to ensure staffing ratios are met per regulations 4) Wellness Director, Memory Care Director 5/12/30/2024	12/30/2024

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	caregiver for every assigned interaction group of not more then six residents during the residents' waking hours in an Alzheimer's endorsed facility on the following dates and times: June 2024 PM shift from 2:00 PM to 10:00 PM - June 17, - June 18 through June 24, - June 28 through 30 July 2024 AM shift from 6:00 AM to 2:00 PM - July 29 July 2024 PM shift from 2:00 PM to 10:00 PM - July 1, - July 3 through 15, - July 17 through 22 - July 24 through 29 \ August 2024 AM shift from 6:00 AM to 2:00 PM - August 5 - August, 12 - August 18 and 19 August 2024 PM shift from 2:00 PM to 10:00 PM - August 4 - August 11 September 2024 AM shift from 6:00 AM to 2:00 PM - September 9 - September 15 and 16 September 2024 PM shift from 2:00 PM to 10:00 PM - September 13 through 15 - September 21 and 22 - September 25 - September 28 and 29 October 2024 AM shift from 6:00 AM to 2:00 PM - October 7 October 2024 PM shift from 2:00 PM to 10:00 PM - October 5 and 6 - October 9 On 10/10/2024 at 2:32 PM, the Administrator confirmed the facility staffing in the memory care unit during the reviewed period of June 17 through October 10, 2024, did not meet the staffing requirement for a facility with an Alzheimer's endorsement. Severity: 2 Scope: 3 Complaint #NV00070679			
0994 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents.	0994	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024

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0999 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility.	0999	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024
1240 SS= C	Patient's Rights - Patient to be informed - NRS 449A.118 Patient to be informed of rights upon admission to facility; required disclosures and notices. [Effective January 1, 2020.] 1. Every medical facility and facility for the dependent shall inform each patient or the patient's legal representative, upon the admission of the patient to the facility, of the patient's rights as listed in NRS 449A.100 and 449A.106 to 449A.115, inclusive. 2. In addition to the requirements of subsection 1, if a person with a disability is a patient at a facility, as that term is defined in NRS 449A.218, the facility shall inform the patient of his or her rights pursuant to NRS 449A.200 to 449A.263, inclusive. 3. In addition to the requirements of subsections 1 and 2, every hospital shall, upon the admission of a patient to the hospital, provide to the patient or the patient's legal representative: (a) Notice of the right of the patient to: (1) Designate a caregiver pursuant to NRS 449A.300 to 449A.330, inclusive; and (2) Express complaints and grievances as described in paragraphs (b) to (f), inclusive; (b) The name and contact information for persons to whom such complaints and grievances may be expressed, including, without limitation, a patient representative or hospital social worker; (c) Instructions for filing a complaint with the Division; (d) The name and contact information of any entity responsible for accrediting the hospital; (e)	1240	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024

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	A written disclosure approved by the Director of the Department of Health and Human Services, which written disclosure must set forth: (1) Notice of the existence of the Bureau for Hospital Patients created pursuant to NRS 232.462; (2) The address and telephone number of the Bureau; and (3) An explanation of the services provided by the Bureau, including, without limitation, the services for dispute resolution described in subsection 3 of NRS 232.462; and (f) Contact information for any other state or local entity that investigates complaints concerning the abuse or neglect of patients. 4. In addition to the requirements of subsections 1, 2 and 3, every hospital shall, upon the discharge of a patient from the hospital, provide to the patient or the patient's legal representative a written disclosure approved by the Director, which written disclosure must set forth: (a) If the hospital is a major hospital: (1) Notice of the reduction or discount available pursuant to NRS 439B.260, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount under that section; and (2) Notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, which policies and procedures are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260. The notice required by this subparagraph must describe the criteria a patient must satisfy to qualify for the additional reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment. (b) If the hospital is not a major hospital, notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons. The notice required by this paragraph must describe the criteria a patient must satisfy to qualify			

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	for the reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment. As used in this subsection, "major hospital" has the meaning ascribed to it in NRS 439B.115. 5. In addition to the requirements of subsections 1 to 4, inclusive, every hospital shall post in a conspicuous place in each public waiting room in the hospital a legible sign or notice in 14-point type or larger, which sign or notice must: (a) Provide a brief description of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, including, without limitation: (1) Instructions for receiving additional information regarding such policies and procedures; and (2) Instructions for arranging to make payment; (b) Be written in language that is easy to understand; and (c) Be written in English and Spanish. (Added to NRS by 1983, 822; A 1985, 1749; 1999, 1053, 3252; 2003, 1880; 2005, 947; 2011, 362, 697; 2019, 537, effective January 1, 2020)			
1540 SS= D	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 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	1540	1) All staff had completed Cultural Training and certificate placed in employee file. 2) New hire check list includes date of Cultural Training completed with Completion Certificate A review all of Staff Members will be completed for complaince. 3) Business Office Manager completes new hire checklist with new employee. Executive Director will review check list to ensure Cultural Training certificate meets the State standard. 4) Business Office Manager and Executive Director 5)12/30/2024	12/30/2024

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	more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the Department or his or her designee pursuant to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, 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. R016-20 Sec. 15 3. When a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the			

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	course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of the course or program to print and sign his or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec.			

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	15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4			

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		A. BUILDING _____ B. WING _____	**10/29/2024**

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	of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by federal, state or local government agencies; or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not			

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	received or fails to include all of the information that the Director or his or her designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program. Inspector Comments: Based on personnel file review, document review, and interview, the facility failed to ensure 2 of 10 employees completed cultural competency training within 30 days of hire (Employee #11 and #14) Findings include: The facility's Plan of Correction dated 07/09/2024, documented facility had utilized on specific company that provides monthly training dates. Specified employees missed the monthly training and took next available class. The facility has located other companies to provide training. The Business Office Manager had a current list of approved companies to provide specified training. The POC documented the correction date as 02/28/2024. Employee #11 Employee #11 was hired by the facility as a Medication Technician with a start date of 03/11/2024. Employee #11's personnel file lacked documented evidence of cultural competency training. Employee #14 Employee #14 was hired as a Resident Care Partner with a start date of 05/06/2024. Employee #14's personnel file documented cultural competency training dated 06/28/2024, 22 days late. On 10/10/2024 at 1:00 PM, the Business Office Manager (BOM) explained employees could start work and complete cultural competency training within 30 days. On 10/10/2024 at 1:22 PM, the BOM confirmed Employee #11 lacked cultural competency training and confirmed Employee #14's cultural competency training was late. This is a repeat deficiency from the Annual State Survey dated 02/28/2024. Severity: 2 Scope: 1			
1700	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct	1700	1) All staff had completed Cultural Training and certificate placed in employee file These previously reviewed certificates did	12/30/2024

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	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 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		not include grades. 2) New hire check list includes date of Cultural Training completed with Completion Certificate A review all of Staff Members will be completed for complaince. 3) Business Office Manager completes new hire checklist with new employee. Executive Director will review check list to ensure Elder Abuse Training certificate meets the State standard. 4) Business Office Manager and Executive Director 5)12/30/2024	

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	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 obtain an annual Standard Physician Assessment and Placement Determinations for a resident with a diagnosis of Alzheimer's disease for 1 of 23 sampled residents (Resident #20). Findings include: Resident #20 Resident #20 was admitted to the facility on 10/15/2018, with a diagnosis of Alzheimer's disease. Discharged 10/25/2024. Resident #1's clinical record included a Standard Physician Assessment and Placement Determination dated 04/19/2023, documented the resident had a cognitive deficit of Alzheimer's disease and the resident was appropriate to reside in an Assisted Living Community, but lacked a completed Standard Physician Assessment and Placement Determination completed in 2024. On 10/29/2024 at 6:10 PM, the Administrator confirmed Resident #20's clinical record lacked a Standard Physician Assessment and Placement Determination completed in 2024. Severity: 2 Scope: 1			
1825 SS= D	I C Program Responsible Person and Designee - IC Program Responsible Person and Designee LCB File No. R048-22 Sec. 5 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times.	1825	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024

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

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1830 SS= F	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.	1830	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 3FIT11.	10/29/2024