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 _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSET RENO MEMORY CARE	**6205 SHARLANDS AVE, RENO, NEVADA ,89523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 08/28/2024, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 103 Residential Facility for Groups beds which provides assisted living services for elderly or disabled persons and/or persons with mental illness and/or persons with Alzheimer's disease, 55 Category II Alzheimer's residents and 48 Category II non-Alzheimer's residents. The census at the time of the survey was 37. Ten resident files were reviewed and fourteen employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. There was one complaint investigated. Complaint #NV00071841 with the allegation the facility failed to protect a resident in memory care from physical abuse could not be substantiated due to a lack of evidence. The investigation into the allegation included: Observations of residents in common areas, residents in rooms, residents participating in activities, staff to resident interactions, resident to resident interactions. Interviews with three residents, three medication technicians, the Resident Services Director, and the Executive	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JESUS BARRIOS Title: executive director Date: 10/31/2024

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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	Director. Record review included face sheets, diagnoses, needs and services plans, physician notes, an incident report, physician orders, facility communication with the physician, and status check documentation. Review of the facility's Incident Reporting Policy and Abuse Policy. 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 deficiencies were identified:			
0102 SS= E	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1) an employee met the requirements for a pre-employment physical examination prior to providing care to residents for 3 of 14 sampled employees (Employee #13 #17 and #18), and 2) a tuberculosis (TB) screening was completed in accordance with Nevada Administrative Code 441A for 2 of 14 sampled employees (Employee #1 and #17). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Physical Exam Employee #13 Employee #13 was hired by the facility as a Med Tech with a start date of 07/19/2024. Employee #13's personnel file documented a physical exam dated 08/14/2024, 26 days after the employee started working with residents. Employee	0102	SS 102 1. How willyou correct the specific findings Employee 13 and 17 no longer here, employee 18 has schedule Blood draw, Employee 1 TB Questionnaire completed 2. What system changes will be put in place Audit sheet to be kept by BOM 3. How the correct actions will be monitored Monthly audits will be completed 4. The title of the person (position) responsiblefor correction is implemented Business office Manager 5. The date the corrective action will be completed October 31, 2024 6. attacheddocument	10/31/2024

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	#17 Employee #17 was hired by the facility as a Caregiver with a start date of 07/25/2024. Employee #17's personnel file lacked documented evidence of a physical exam prior to employment. Employee #18 Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. Employee #18's personnel file documented a physical exam dated 05/28/2024, three days after the employee started working with residents. TB screening Employee #1 Employee #1 was hired by the facility as the Executive Director with a start date of 07/01/2023. Employee #1's personnel file documented a positive QuantiFERON tested dated 06/07/2023 and a negative chest x-ray dated 06/19/2023. Employee #1's personnel file lacked documented evidence of a TB screening questionnaire for 2024. Employee #17 Employee #17 was hired by the facility as a Caregiver with a start date of 07/25/2024. Employee #17's personnel file lacked documented evidence of a two-step TB test prior to employment. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed employee #13 #17 and #18 did not meet the pre-employment physical exam requirements prior to working in the facility lacked and Employee #1 and #17 did not complete the tuberculosis (TB) screening requirements. Severity: 2 Scope: 2		7. How you will identify and correct the otherareas having potential to be affected by the same practice With the monthly audit will be reviewedquarterly to ensure compliance	
0104 SS= F	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on personnel record review, document review, and interview, the Administrator failed to ensure 10 of 14 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #8, #9, #10, #11, #12, #13, #14,	0104	SS 104 1. How willyou correct the specific findings Employee 12,13,14,15,17 no longer here. All staffwill be hired thru Business office manger for timely fingerprint and backgroundchecks 2. What system changes will be put in place All staff hired will be processed thru the Business officemanger	10/31/2024

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	#15, #16, and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 11/10/2023. Employee #8's personnel file documented the employee's fingerprints were taken on 08/16/2024, nine months after the hire date. Employee #9 Employee #9 was hired by the facility as a Caregiver/Med Tech with a start date of 06/01/2024. Employee #9's personnel file documented the employee's fingerprints were taken on 08/21/2024, eleven weeks after the hire date. Employee #10 Employee #10 was hired by the facility as a Caregiver/Med Tech with a start date of 01/07/2024. Employee #10's personnel file documented the employee's fingerprints were taken on 04/18/2024, fourteen weeks after the hire date. Employee #11 Employee #11 was hired by the facility as a Caregiver/Med Tech with a start date of 05/07/2024. Employee #11's personnel file documented the employee's fingerprints were taken on 08/17/2024, more than three months after the hire date. Employee #12 Employee #12 was hired by the facility as a Caregiver with a start date of 07/16/2024. Employee #12's personnel file documented the employee's fingerprints were taken on 08/26/2024, five weeks after the hire date. Employee #13 Employee #13 was hired by the facility as a Med Tech with a start date of 07/19/2024. Employee #13's personnel file documented the employee's fingerprints were taken on 08/14/2024, four weeks after the hire date. Employee #14 Employee #14 was hired by the facility as a Caregiver/Med Tech with a start date of 02/15/2024. Employee #14's personnel file documented the employee's fingerprints were taken on 04/22/2024, two months after the hire date. Employee #15 Employee #15 was hired by		3. How the correct actions will be monitored Audit checklist will be put in place 4. The title of the person (position) responsiblefor correction is implemented\ Business office manger will be responsible for actions 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Monthly review for 3 months then quarterlyreview of audit check list	

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	the facility as a Caregiver/Med Tech with a start date of 09/29/2023. Employee #15's personnel file documented the employee's fingerprints were taken on 03/22/2024, six months after the hire date. Employee #16 Employee #16 was hired by the facility as a Caregiver with a start date of 07/16/2024. Employee #16's personnel file documented the employee's fingerprints were taken on 08/13/2024, one month after the hire date. Employee #18 Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. Employee #18's personnel file documented the employee's fingerprints were taken on 08/09/2024, ten weeks after the hire date. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed Employee #8, #9, #10, #11, #12, #13, #14, #15, #16, and #18 had not completed the required background check timely. Severity: 2 Scope: 3			
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 8/28/24, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. Multiple expired foods in the kitchen walk-in refrigeration were observed at the time of inspection. The following preparation dates were observed: roast turkey 8/13/24, sausage marinara 8/8/24; cannoli filling 8/20/24; meatball soup 8/20/24; carne sauce 8/17/24; hot and sour soup 8/6/24. In addition, a cottage cheese container had a manufacturer's best by expiration date of 8/1/24. All expired food was observed discarded by end of the inspection. Interview with kitchen staff did not indicate a	0255	SS 255 1. 1 All items were discard (b) Pump was replaced(c) Chemical were removed (d) dog food was discarded 2. All items were discarded. (b)floors were swept (c) dumpster area was washed 3. Ice machine was tuned off (b)closet sink repaired 2. What system changes will be put in place Daily foodinspection and weekly rounds on items identified 3. How the correct actions will be monitored 5 day a week inspection and weekly check off rounds 4. The title of the person (position) responsiblefor correction is implemented\	10/31/2024

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	daily monitoring system for identifying expired food. b. The three-compartment sink quaternary sanitizer pump was not mixing and dispensing the correct amount of sanitizer at the time of inspection. No residual sanitizer was observed at the three-compartment sink or in wiping cloth sanitizer buckets. The solutions were tested with inspector and facility quaternary test strips. c. Multiple chemicals were not accounted for with-in the kitchen janitor's closet and second floor serving kitchen. Labels on chemical spray bottles were not provided or did not reflect their chemical contents. In addition, several different types of sanitizers, disinfectants, cleaning agents, and deodorizers were observed within the kitchen janitor's closet on shelving, in chemical dispensing pumps, spray bottles, bulk containers and in unorganized boxes. Interview with kitchen staff revealed no training or directions on the application of these chemicals had been given with regards to the chemical types, application guidelines, personal protection, exposure, reactivity, storage conditions, and monitoring. d. Food labeled for "dog food donation" was observed in the resident server line reach-in refrigerator. 2. Major Violations: a. Multiple stored food items in the kitchen walk-in refrigerator were either not labeled and dated or the labels and dates were not legible. b. The floors throughout the kitchen under mounted equipment were heavily soiled with food debris. This was also observed under the dishwashing machine. In addition, floor sinks had heavy accumulation of food debris, especially under the dishwashing machine. c. The dumpster area enclosure had excessive garbage compacter seepage. The area also had a foul odor. 3. Equipment and Maintenance Violations: a. The server line ice machine was not draining properly at the time of inspection. Melted ice water was accumulating inside the machine. b. The janitor's closet sink faucet was in disrepair. The vacuum		Dietary Manager 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice logs will bemonitored weekly and reviewed quarterly for compliance	

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	breaker valves were leaking at the connections with the faucet outlet, and at the top of the faucet between the turn off valves. Severity: 2 Scope: 3			
0450 SS= E	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 record review, document review, and interview, the facility failed to ensure employees obtained timely cardiopulmonary resuscitation (CPR) and first aid training for 4 of 14 sampled employees working at the facility greater than 30 days (Employee #10, #14, #17, and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Employee #10 Employee #10 was hired by the facility as a Caregiver/Med Tech with a start date of 01/07/2024. Employee #10's personnel file contained documented evidence of CPR and first aid training dated 05/25/2024. Employee #14 Employee #14 was hired by the facility as a Caregiver/Med Tech with a start date of 02/15/2024. Employee #14's personnel file contained documented evidence of CPR and first aid training dated 07/06/2024. Employee #17 Employee #17 was hired by the facility as a Caregiver with a start date of 07/25/2024. Employee #10's personnel file lacked documented evidence of CPR and first aid training. Employee #18 Employee #18 was hired by the facility as a	0450	SS 450 1. How willyou correct the specific findings 10 and 14 no longer employed. 10 has a cpr card and 17 CPR rescheduled training. 2. What system changes will be put in place Business office manger to mange all new staff and no one 3. How the correct actions will be monitored Employee audit checklist will be put inplace for monitoring 4. The title of the person (position) responsiblefor correction is implemented\ Business office manger 5. The date the corrective action will be completed10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Audit list will be reviewed weekly for 3 months andquarterly.	10/31/2024

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	Caregiver with a start date of 05/25/2024. Employee #18's personnel file lacked documented evidence of CPR and first aid training. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed Employee #10, #14, #17, and #18 lacked timely CPR and first aid training within 30 days of their hire date. Severity: 2 Scope: 2			
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to ensure a person-centered service plan related to diabetes mellitus type II was developed to address the facility's treatment of residents for 1 of 10 sampled residents reviewed for service plans (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/29/2024, with diagnoses including diabetes mellitus type II, coronary artery disease, and dementia. On 08/28/2024 at 1:09 PM, the Resident Services Director confirmed the facility had not created a person-centered service plan related to the care and treatment of diabetes mellitus type II for Resident #1. The facility policy titled "Service Plans," undated, documented the purpose of the service plan was to provide a centralized coordination of the services that would be provided to each resident, based on individual needs, abilities, and preferences. The service plan would include the following: acitivities of daily living, medication management and/or assistance	0515	SS 515 1. How willyou correct the specific findings Resident no longer here. 2. What system changes will be put in place Service plan to be review upon admission, change of condition and annually 3. How the correct actions will be monitored All new admission will be processed by Resident CareDirector or memory care director and review at change of condition and annually 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director and or Memory Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be	10/31/2024

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	required, and physical needs related to illness/chronic disease management. Severity: 2 Scope: 1		affected by the same practice Resident care list will be reviewed whenchanges occur and annually	
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the	0690	690 1. How willyou correct the specific findings Oxygen tank was put in holder 2. What system changes will be put in place Caregiver will do rounds daily 3. How the correct actions will be monitored Will add to service plan and will check off with ADL 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice All residents with oxygen will have service plan updated andreviewed with care changes and annually.	10/31/2024

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	resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured in the oxygen storage room. Findings include: On 08/28/24 at 12:15 PM, Room #104 contained one size B oxygen cylinder sitting directly on the floor. On 08/28/24 at 12:15 PM, the Resident Care Director confirmed the oxygen tank was not secured and verbalized oxygen tanks should be kept secured at all times. Severity: 2 Scope: 1			
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 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)	0878	878 1. How willyou correct the specific findings 1 we got doctors orders 2 we affixed change labels to reflect physician orders 3 medication was delivery by pharmacy 2. What system changes will be put in place Med audit done once month to match physician orders. If there is a medication change check change label is completed. When pharmacy issue on medication will followup with a call. 3. How the correct actions will be monitored Monthly medication audit 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed 10-31-24	10/31/2024

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		A. BUILDING _____ B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSET RENO MEMORY CARE	**6205 SHARLANDS AVE, RENO, NEVADA ,89523**

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	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 (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on clinical record review and interview, the facility failed to 1) provide documented evidence of written medication instructions from a physician, 2) ensure medications had change labels affixed and accurately reflected the physician orders, and 3) ensure medications were on-site to administer as prescribed for 2 of 10 sampled residents (Resident #4 and #6). Findings include: Resident #4 Resident #4 was admitted to the facility on 01/21/2024, with diagnoses including age related cognitive decline, glaucoma, hypertension, and anxiety disorder. Medication Instructions Resident #4's Medication Administration Record (MAR) dated August 2024, documented Vitamin D Capsule 50000 unit, take 1 capsule by mouth every seven days for supplement. On 08/28/2024 at 3:34 PM, the Medication Technician verbalized Resident #4's medical record did not contain a physician's order for Vitamin D. Change Labels Resident #4's physician order dated 08/22/2024, documented		6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Monthly audit will be reviewed for 3 months to ensurecompliance and if more training is required.	

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	Vitamin B-12 tablet 500 micrograms (mcg), take two tablets (1000 mcg) by mouth once daily. Resident #4's MAR documented Vitamin B-12 tablet 500 mcg, take one tablet by mouth once daily. Resident #4's medication card for Vitamin B-12 documented Vitamin B-12 tablet 500 mcg, take two tablets by mouth daily. On 08/28/2024 at 3:12 PM, the MT confirmed Resident #4's MAR did not match the resident's physician order for Vitamin B-12. The MT explained the physician order should have been accurately transcribed by an MT and a change label should have been affixed to the medication to reflect the new instructions. The MT confirmed no other orders for Vitamin B-12 were found in Resident #4's medical record. Medications Available Resident #4's Medication Administration Record (MAR) documented the following: -Buspirone tablet 7.5 milligrams (mg), give one tablet by mouth twice daily. The MAR documented Resident #4 did not receive buspirone on the following dates/times: -08/04/2024: 5:00 PM -08/05/2024: 5:00 PM -08/06/2024: 8:00 AM and 5:00 PM -08/07/2024: 5:00 PM -08/14/2024: 5:00 PM -08/15/2024: 8:00 AM and 5:00 PM On 08/28/2024 at 2:51 PM, the Medication Technician (MT) confirmed resident #4 did not receive buspirone on the above dates because the medication was out of stock and needed to be refilled. The MT explained the process for missing medications was to call or fax the pharmacy to see why the medication had not been delivered. The MT confirmed the medication was not on site for administration. The facility policy titled "Medication Refills," undated, documented the Resident Care Director or the Med Tech would contact the dispensing pharmacy to obtain a medication refill at least seven days prior to running out of a medication. Medications were never allowed to run out unless directed and documented by the physician. Containers were inspected to ensure all information on the label was correct. The physician order,			

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	MAR, and pharmacy label had to match exactly for proper dispensing. The facility policy titled "Medication Labels," undated, documented in order to maintain a label that matches a current physician order, the medication container would be flagged with a brightly colored sticker and would contain the following in handwriting : "Order changed, see MAR," with the date, time, and staff initials. Staff would highlight the old order in the MAR and would write "order changed," with the physician's name, date, time, and staff initials. The Resident Care Director or medication technician was responsible to transcribe orders to the MAR. Resident #6 Resident #6 was admitted to the facility on 08/04/2024, with diagnoses including mild cognitive impairment, chronic left knee pain and osteoporosis. Resident #6's August 2024 Medication Administration Record (MAR) and physician's order documented the following medications were not onsite during the resident's medication review: -Azelastine Hydrochloride (HCl) 200 metered sprays 205.5 micrograms (mcg)/0.137 milliliters (ml), use two sprays in each nostril twice daily. -Calcium/Magnesium/Zinc 250 mg tablet, take one tablet by mouth daily. -Hair, Skin and Nails 5000 units tablet, take one tablet by mouth daily. -Narcan Spray 4 mg, spray one spray in each nostril as needed for symptoms of overdose. On 08/28/2024 at 2:21 PM, the Resident Services Director confirmed Resident #6's Azelastine hydrochloride, Calcium/Magnesium/Zinc, Hair/Skin and Nails and Narcan medications were not onsite. 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	0895	895 1. How willyou correct the specific findings Resident no longer here	10/31/2024

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	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 document review, clinical record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 10 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/29/2024, with a diagnoses of coronary artery disease, glaucoma, and diabetes mellitus type two. Resident #1's MAR dated August 2024, documented the following: -Accu-chek test guide strips, use one strip to test blood glucose four times a day. -Softclix lancets, use one lancet three times a day with test strips to test blood glucose. Resident #1's Physician Order dated 07/24/2024, documented the following: -Accu-chek guide test strip, use one strip for testing five times a day to test blood glucose. - Lancet, Softclix, use lancet five times a day with test strips to test blood glucose. The MAR documented an exception note dated 08/12/2024, under Medication/Treatment for the Accu-chek guide and the Softclix lancets were to only be three times daily. On 08/28/2024 at 2:34 PM, the Medication Technician (MT) confirmed the Accu-Chek		2. What system changes will be put in place Monthly review medication audit to include MAR and physicianorders 3. How the correct actions will be monitored Monthly report will show reason for medication not given. 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Reports will be review for any issues of medication in theMAR	

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	blood glucose testing strips were used with the Softclix lancets to test Resident #1's blood glucose. The MT confirmed the instructions for the frequency of the testing strips and lancets did not match the physician orders and could cause a confusion for the frequency of use. The MT confirmed the MAR was inaccurate. Severity: 2 Scope: 1			

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0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on interview, clinical record review, and document review, the facility failed to ensure written instructions indicating the specific symptom (s) for which a PRN medication was to be given was documented for 1 of 10 sampled residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 01/21/2024, with diagnoses including age related cognitive decline, glaucoma, hypertension, and anxiety disorder. On 08/28/23 at 3:27 PM, Resident #4's medications included the following as needed (PRN) medication: -Robafen CF liquid 5-10-100, take 5 milliliters (ml) every eight hours as needed. Resident #4's August 2024 Medication Administration Record (MAR) documented Robafen CF liquid 5-10-100, take 5 ml every eight hours as needed On 08/28/2024 at 3:28 PM, the Medication Technician confirmed Resident #4's Robafen CF medication label and MAR entry lacked the specific symptom(s) for which a PRN medication was to be given. Severity: 2 Scope: 1	0905	905 1. How willyou correct the specific findings Symptom add for reason to be given 2. What system changes will be put in place During medication audits will ensure all medication have reason to be given. 3. How the correct actions will be monitored Monthly Audits 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Monthly audits to be review for compliance for 3 months	10/31/2024

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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 and interview, the facility failed to ensure over-the-counter (OTC) medication bottles contained the prescriber's name for 1 of 10 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/29/2024, with diagnoses including diabetes mellitus type II, coronary artery disease, glaucoma, and dementia. On 08/28/2024 at 2:11 PM, during the medication review and in the presence of a Medication Technician, the following were found with Resident #1's active medications: -Aspirin low tab 81 milligrams (mg), take one tablet by mouth once daily. -Dorzol/Timol solution 2-0.5 % Ophthalmic, instill one drop in both eyes every 12 hours for glaucoma. Close eyes for five minutes after instilling drops. The bottles lacked the resident's and prescriber's names. On 08/28/2024 at 2:13 PM, the Medication Technician confirmed the bottle of Aspirin and Dorzol/Timol solution lacked the resident's and prescriber's names. Severity: 2 Scope: 1	0923	923 1. How will you correct the specific findings We got a new label with resident name and doctor name, resident no longer here 2. What system changes will be put in place. Medication audit to identify any issues with label that have resident names and doctor's name. 3. How the correct actions will be monitored Medication audit done monthly 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Monthly audits to be reviewed for compliance.	10/31/2024
0936	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents	0936	936	10/31/2024

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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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on document review, clinical record review and interview, the facility failed to ensure 2 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #6 and #8). Findings include: Resident #6 Resident #6 was admitted to the facility on 08/04/2024, with diagnoses including mild cognitive impairment, chronic left knee pain and osteoporosis. Resident #6's clinical record contained a one-step TB test given on 12/27/2023 and read negative on 12/31/2023. The clinical record lacked a second step TB test. On 08/28/2024 at 3:14 PM, the Resident Services Director (RSD) verbalized a two-step TB test was required to be completed upon admission to the facility. The RSD confirmed Resident #6 lacked a second step TB test completed. Resident #8 Resident #8 was admitted to the facility on 01/31/2024, with a diagnosis of vascular dementia. Resident #8's clinical record contained a one-step TB test given on 05/29/2023 and read negative on 05/31/2023, however lacked documented evidence of a TB completed in 2024. On 08/28/2024 at 3:08 PM, the Resident Services Director (RSD) verbalized a TB testing was to be completed annually. The RSD confirmed Resident #8 lacked evidence of an annual TB test completed.		1. How willyou correct the specific findings TB blood drawn was ordered for both residents 2. What system changes will be put in place All New residents will have T B completed 3. How the correct actions will be monitored AL advantage will have a monthly report to review when TBare do 4. The title of the person (position) responsiblefor correction is implemented\ Resident care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Monthly report will be reviewed on a quarterly basis.	

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	Severity: 2 Scope: 1			
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 10 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 03/31/2024, with diagnoses including peripheral vascular disease, hypothyroidism, anxiety, and deep vein thrombosis in left lower extremity. Resident #5's clinical record lacked documented evidence an ADL assessment had been completed since admission. On 08/28/2024 at 12:24 PM, the Resident Care Director confirmed an ADL assessment was not completed for Resident #5 upon admission and had thought the prior facility's history and physical would take the place of the need for an ADL assessment. On 08/28/2024 at	0938	938 1. How willyou correct the specific findings ADL assessment completed on resident 5 2. What system changes will be put in place ADl assessment will be completed upon admit, change of condition or annually 3. How the correct actions will be monitored The service plan will be updated with ADL update 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Monthly service plans report will be reviewed monthly andquarterly.	10/31/2024

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	12:52 PM, the Administrator explained the ADL needs documented by the previous facility was used as the ADL assessment and confirmed there was not a current ADL assessment in the resident's clinical record. Severity: 2 Scope: 1			
0992 SS= E	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: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768. Inspector Comments: Based on personnel record review, document review, and interview the facility failed to ensure two hours of tier 2 Alzheimer's training was completed within 40 hours and eight hours of tier 2 training for Alzheimer's care was completed within 90 days of hire and three hours annually for 5 of 14 sampled employees (Employee #1, #8, #11, #14 and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as the Executive Director with a start date of 07/01/2023. Employee #1's personnel file lacked documented evidence	0992	992 1. How willyou correct the specific findings New hours assigned to all staff members to complete 2. What system changes will be put in place All hours we be assigned by Business Office Manager for Relias 3. How the correct actions will be monitored Employee audit checklist will be used to monitor 4. The title of the person (position) responsiblefor correction is implemented\ Business Office Manager 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice	10/31/2024

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	of three hours of annual tier 2 Alzheimer's training for 2024. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 11/10/2023. Employee #8's personnel file documented only two hours of tier 2 initial Alzheimer's training. Employee #11 Employee #11 was hired by the facility as a Caregiver/Med Tech with a start date of 05/07/2024. Employee #11's personnel file documented only two hours of tier 2 initial Alzheimer's training. Employee #14 Employee #14 was hired by the facility as a Caregiver/Med Tech with a start date of 02/15/2024. Employee #14's personnel file lacked documented evidence of tier 2 initial Alzheimer's training. Employee #18 Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. Employee #18's personnel file documented only two hours of tier 2 initial Alzheimer's training. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed Employee #1 lacked the three hours of annual Alzheimer's training and Employee #8, #11, #14, and #18 lacked the 10 hours of initial Alzheimer's training within 90 days of hire. Severity: 2 Scope: 3		Employee audit checklist will be monitored weekly andmonthly	
0994 SS= F	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. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to 16 of 16 residents in memory care. Findings include: On 08/28/24 between 9:30 AM and	0994	994 1. How willyou correct the specific findings All items were removed (razors, nail clippers, shampoo, hand lotion) 2. What system changes will be put in place We contacted families to let them know, we could have electric razors but not shavers due to the blade. We also informed them via letter that allexcess shampoo, hand lotion or anything that could be ingested will have to belocked up. 3. How the correct actions will be monitored	10/31/2024

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		A. BUILDING _____ B. WING _____	**08/28/2024**

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	10:45 AM, the following rooms listed, housing memory care residents contained toxic items: 201, 203, 204, 208, 209, 210, 207, 208, 209, 210, 217, 218, 219, 223, 226, 228, 230, 231, and 232. With the following items found: - hand held razors for shaving - finger nail clippers with a metal nail file attached - metal nail files On 08/28/24 at 10:45 AM, the Executive Director verbalized the possibly dangerous items should be inaccessible to residents in the memory care unit. The Administrator verbalized the previous Resident Care Director was in charge of room checks in the memory care unit and wasn't sure if they room checks were being done. On 08/28/24 at 11:25 AM, the interim Resident Care Director confirmed that room checks were not being completed on a regular basis. On 08/28/2024 at 9:39 AM, the Executive Director confirmed the facility policy, "Environmental Safety," documented, "The memory care unit will be assessed for items which could be misperceived by resident as something to eat or drink and will be safely stored in an inaccessible location to residents." The policy also documented, "Any personal items that may represent a weapon such as guns, knives, or razors perceived as potentially hazardous shall not be stored or maintained within resident rooms." Severity: 2 Scope: 3		The round will be added to the service plan and will be usedto monitor 4. The title of the person (position) responsiblefor correction is implemented\ Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Service plans will be reviewed monthly to ensure compliance	
1001 SS= E	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. Inspector Comments: Based on personnel record review, document review, and interview, the facility failed to ensure 6 of 14 sampled employees working at the facility	1001	1001 1. How willyou correct the specific findings New check off list will be performed with employees 9,11,16, 18. 2. What system changes will be put in place All staff hired will be add to the employee audit checklist for compliance	10/31/2024

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	greater than 60 days and less than one year received four hours of initial training to care for elderly or disabled residents, within 60 days of hire (Employee #9, #11, #12, #14, #16, and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Employee #9 Employee #9 was hired by the facility as a Caregiver/Med Tech with a start date of 06/01/2024. Employee #9's personnel file lacked documented evidence of training to care for elderly or disabled residents. Employee #11 Employee #11 was hired by the facility as a Caregiver/Med Tech with a start date of 05/07/2024. Employee #11's personnel file lacked documented evidence of training to care for elderly or disabled residents. Employee #12 Employee #12 was hired by the facility as a Caregiver with a start date of 07/16/2024. Employee #12's personnel file lacked documented evidence of training to care for elderly or disabled residents. Employee #14 Employee #14 was hired by the facility as a Caregiver/Med Tech with a start date of 02/15/2024. Employee #14's personnel file lacked documented evidence of training to care for elderly or disabled residents. Employee #16 Employee #16 was hired by the facility as a Caregiver with a start date of 07/16/2024. Employee #16's personnel file lacked documented evidence of training to care for elderly or disabled residents. Employee #18 Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. Employee #18's personnel file lacked documented evidence of training to care for elderly or disabled residents. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed Employee #9, #11, #12, #14, #16, and #18 worked at the facility and did not have documented evidence of caregiver training in their respective personnel files		3. How the correct actions will be monitored The Audit checklist will be reviewed weekly 4. The title of the person (position) responsiblefor correction is implemented\ Business Office Manager 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice The audit checklist will be reviewed with the Businessoffice Manager by the Executive Director	

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

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	maintained in the facility. Severity: 2 Scope: 2			

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0050 SS= F	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, clinical record review, document review, and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAG Y0074, Y0102, Y0104, Y0255, Y0450, Y0515, Y0690, Y0878, Y0885, Y0895, Y0905, Y0923, Y0936, Y0938, Y0992, Y0994, Y0999, Y1001, Y1011, Y1540, Y1600, Y1700, and Y1825. Severity: 2 Scope: 3	0050	50 1. How will you correct the specific findings Executive Director to hold QA meeting quarterly to provide oversight 2. What system changes will be put in place Audit checklist and other correction items to be reviewed monthly 3. How the correct actions will be monitored Reports brought to meeting 4. The title of the person (position) responsiblefor correction is implemented\ Executive director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Team to review and direction to be provide by ExecutiveDirector.	10/31/2024

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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 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	0074	74 1. How willyou correct the specific findings #1 redo training, 2,17, no longer here, 8,9,10, 18 redoing training. 2. What system changes will be put in place New employee audit checklist will be put in place to monitor timeliness 3. How the correct actions will be monitored Employee audit checklist to be used and review weekly forcompliance 4. The title of the person (position) responsiblefor correction is implemented\ Business office Manager 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Employee audit form will be brought to monthly QA meetingsto be reviewed.	10/31/2024

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	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 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			

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	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 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 and interview, the Administrator failed to ensure 7 of 14 sampled employees received initial elder abuse training prior to beginning work at the facility or received annual elder abuse prevention training (Employee #1, #2, #8, #9, #10, #17, and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as the Executive Director with a start date of 07/01/2023. Employee #1's personnel file documented an initial elder abuse prevention training was completed on 06/19/2023. Employee #1's personnel file lacked documented evidence of elder abuse prevention training for 2024. Employee #2 Employee #2 was hired by the facility as the Resident Service Director with a start date of 04/01/2024. Employee #2's personnel file documented elder abuse prevention training dated 04/03/2024, two days after working with residents. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 11/10/2023. Employee #8's personnel file documented elder abuse prevention training dated 01/17/2024, 67 days after working with			

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	residents. Employee #9 Employee #9 was hired by the facility as a Caregiver/Med Tech with a start date of 06/01/2024. Employee #9's personnel file documented elder abuse prevention training dated 08/28/2024, 78 days after working with residents. Employee #10 Employee #10 was hired by the facility as a Caregiver/Med Tech with a start date of 01/07/2024. Employee #10's personnel file lacked documented evidence of elder abuse prevention training. Employee #17 Employee #17 was hired by the facility as a Caregiver with a start date of 07/25/2024. Employee #17's personnel file lacked documented evidence of elder abuse prevention training. Employee #18 Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. Employee #18's personnel file lacked documented evidence of elder abuse prevention training. On 08/28/2024 at 11:58 AM, the Business Office Manager confirmed Employee #1, #2, #8, #9, #10, #17, and #18 lacked timely initial or annual elder abuse prevention training prior to working in the facility. Severity: 2 Scope: 3			
1011 SS= F	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. Inspector Comments: Based on personnel record review, document review, and interview, the facility failed to ensure 12 of 14 sampled employees working at the facility greater than 60 days and less than one year received eight hours of initial training to care for residents with a mental illness, within 60 days of hire (Employee #1,	1011	1011 1. How willyou correct the specific findings Training has been assigned to all staff to complete 2. What system changes will be put in place New training has been added to the employee audit checklist. 3. How the correct actions will be monitored Employee Audit check list will be reviewed weekly	10/31/2024

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	#2, #15, #5, #8, #9, #10, #11, #12, #14, #16, and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as the Executive Director with a start date of 07/01/2023. Employee #1's personnel file documented seven and one-half hours of mental illness training. Employee #2 Employee #2 was hired by the facility as the Resident Services Director with a start date of 04/01/2024. Employee #2's personnel file documented six hours of mental illness training. Employee #15 Employee #15 was hired by the facility as a caregiver/Med Tech with a start date of 09/29/2023. Employee #15's personnel file documented four and one-half hours of mental illness training. The following employees lacked documented evidence of training to care for residents with a mental illness: - Employee #5 was hired by the facility as a Med Tech with a start date of 07/16/2024. - Employee #8 was hired by the facility as a Caregiver with a start date of 11/10/2023. - Employee #9 was hired by the facility as a Caregiver/Med Tech with a start date of 06/01/2024. - Employee #10 was hired by the facility as a Caregiver/Med Tech with a start date of 01/07/2024. - Employee #11 was hired by the facility as a Caregiver/Med Tech with a start date of 05/07/2024. - Employee #12 was hired by the facility as a Caregiver with a start date of 07/16/2024. - Employee #14 was hired by the facility as a Caregiver/Med Tech with a start date of 02/15/2024. - Employee #16 was hired by the facility as a Caregiver with a start date of 07/16/2024. - Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed Employee #1, #2, #5, #8, #9, #10, #11, #12,		4. The title of the person (position) responsiblefor correction is implemented\ Business office Manager 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Employee Audit checklist will brought to monthly meetingsfor review and quarterly QA	

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	#14, #15, #16, and #18 lacked the 8 hours of mental illness training within 60 days of hire. Severity: 2 Scope: 3			
1540 SS= F	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 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	1540	1540 1. How willyou correct the specific findings All staff have been assigned cultural competency training 2. What system changes will be put in place All new hires will be put on the employee Audit checklist 3. How the correct actions will be monitored Weekly review of Employee Audit Checklist. 4. The title of the person (position) responsiblefor correction is implemented\ Business office Manager 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Employee Audit checklist to be review monthly and quarterly	10/31/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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			

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		A. BUILDING _____ B. WING _____	**08/28/2024**

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	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. 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			

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	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 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			

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	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 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 record review and interview, the facility failed to ensure cultural competency training was completed for 10 of 14 sampled employees required to obtain cultural competency training (Employee #2, #5, #8, #9 #10, #11, #12, #14, #16, #17 and #18). Findings include: On 08/28/2024 at 9:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 14 sampled employees. On 08/28/2024 at 12:36 PM, the Business Office Manager provided the completed form with the following information: The following employees lacked cultural competency training within 30 days of being hired: - Employee #2 was hired by the facility as the Resident Services Director			

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	with a start date of 04/01/2024. - Employee #5 was hired by the facility as a Med Tech with a start date of 07/16/2024. - Employee #8 was hired by the facility as a Caregiver with a start date of 11/10/2023. - Employee #9 was hired by the facility as a Caregiver/Med Tech with a start date of 06/01/2024. - Employee #10 was hired by the facility as a Caregiver/Med Tech with a start date of 01/07/2024. - Employee #11 was hired by the facility as a Caregiver/Med Tech with a start date of 05/07/2024. - Employee #12 was hired by the facility as a Caregiver with a start date of 07/16/2024. - Employee #14 was hired by the facility as a Caregiver/Med Tech with a start date of 02/15/2024. - Employee #16 was hired by the facility as a Caregiver with a start date of 07/16/2024. - Employee #17 was hired by the facility as a Caregiver with a start date of 07/25/2024. - Employee #18 was hired by the facility as a Caregiver with a start date of 05/25/2024. On 08/28/2024 at 2:00 PM, the Business Office Manager confirmed Employee #2, #5, #8, #9 #10, #11, #12, #14, #16, #17 and #18 lacked the required cultural competency training. Severity: 2 Scope: 3			
1600 SS= A	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records	1600	1600 1. Face sheet of resident 6 updated to show pronoun 2. Face sheet of resident to be audit after admission and quarterly to ensure pronouns are updated 3. Face sheets will be reviewed upon admission and change of condition and annually 4. The title of the person (position) responsiblefor correction is implemented	10/31/2024

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	adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not		Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Face sheet will review quarterly to ensurepronouns are selected.	

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	read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure resident records reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 1 of 10 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 08/04/2024, with diagnoses including mild cognitive impairment, chronic left knee pain and osteoporosis. Resident #6's clinical record lacked documentation to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation. On 08/28/2024 at 3:12 PM, the Resident Services Director (RSD) confirmed Resident #6's clinical record lacked documentation to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation. The RSD explained all admission documentation was to be reviewed by the RSD and the Memory Care Director. Severity: 1 Scope: 1			
1700 SS= E	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	1700	1700 1. How will you correct the specific findings Updated sheets have been placed in their file 2. What system changes will be put in place When a resident moves floors we will have a new one sign byphysician 3. How the correct actions will be monitored	10/31/2024

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	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 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 observation, record review, and interview, the facility failed to ensure resident medical records were complete or accurate for 3 of 10 sampled residents (Resident #3, #7, and #10). Findings include: Resident #3 Resident #3 was admitted to the facility on 05/25/2024, with diagnoses including moderate late onset Alzheimer's dementia without behavioral disturbance. Resident #3's clinical record had an initial Physician Placement Determination but did not		When any change of condition and annually sheet stated wherethey can live will be reviewed 4. The title of the person (position) responsiblefor correction is implemented Resident Care Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice Sheet will be reviewed with change of service program andannually	

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	include an indication of placement determination by the physician. On 08/28/2024 at 3:09 PM, the Administrator confirmed the initial Physician Placement Determination was left blank and was incomplete. Resident #7 Resident #7 was admitted to the facility on 07/11/2024, with diagnoses including Alzheimer's disease and seizure disorder. Resident #7's clinical record had an initial Physician Placement Determination completed 07/03/2024, however documented the resident did not require to reside in secured unit. Resident #7 resided in a locked memory care secured unit. On 08/28/2024 at 3:00 PM, the Resident Services Director verbalized Resident #7 did need to be in a locked memory care secured unit and confirmed the initial Physician Placement Determination was inaccurate. Resident #10 Resident #10 was admitted to the facility on 11/17/2023, with diagnoses including Alzheimer's disease, dementia with behavioral disturbances, agitation and hyponatremia. Resident #10's clinical record had an initial Physician Placement Determination completed 10/18/2023, however documented the resident did not require to reside in secured unit. Resident #10 resided in a locked memory care secured unit. On 08/28/2024 at 3:00 PM, the Resident Services Director verbalized Resident #10 did need to be in a locked memory care secured unit and confirmed the initial Physician Placement Determination was inaccurate. Severity: 2 Scope: 2			

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

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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. Inspector Comments: Based on interview and document review, the facility failed to ensure a secondary person was designated to be responsible for the facility's infection control program with the potential to affect 37 of 37 residents. Findings include: On 08/28/2024 at 10:30 AM, the facility lacked documented evidence to identify a secondary person responsible for the facility's infection control program. On 08/28/2024 at 10:36 AM, the Executive Director confirmed the facility had not designated a secondary person responsible for the facility's infection control program. The Executive Director verbalized the previous secondary person was no longer employed by the facility. Severity: 2 Scope: 1	1825	1825 1. How will you correct the specific findings We will have new Resident Care director do CDC infection prevention 2. What system changes will be put in place Resident care director and memory care director to have CDC training. 3. How the correct actions will be monitored Audit of employee audit checklist will include infectcontrol 4. The title of the person (position) responsiblefor correction is implemented\ Executive Director 5. The date the corrective action will be completed 10-31-2024 6. The attached document 7. How you will identify and correct the otherareas having potential to be affected by the same practice CDC sheet will be brought to quarterly meeting	10/31/2024