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 _____	**03/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESCALANTE AT THE LAKES	**2620 LAKE SAHARA DRIVE, LAS VEGAS, NEVADA ,89117**

(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 and Complaint Investigation survey completed on 03/22/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 150 Residential Facility for Group beds for elderly and disabled persons, with endorsements for Assisted Living, Alzheimer's disease, and mental illness, Category II residents. The census at the time of the survey was 55. Seventeen resident files and 10 employee files were reviewed. The facility received a grade of D. One complaint was investigated: Unsubstantiated: Complaint #NV00070298 was unsubstantiated. No regulatory deficiencies could be identified. Investigation of the complaint included: Observation of residents who did not appear in pain, fall risk residents and fall risk precautions in place. Interviews were conducted with residents, Caregivers, Medication Technicians, the Health Services Director, a Hospice Nurse and the Administrator. Record review of five residents, including the resident of concern. Document reviews including incident reports, policy on falls management and policy on pain management. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROBERT SANDERSWON | Title: Administrator | Date: 05/14/2024

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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0050 SS= I	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, interview, and document review, the facility Administrator failed to provide oversight and direction for members of the staff of the facility as necessary to ensure all residents received needed services and protective supervision. The facility failed to ensure the facility's dry automatic sprinkler and the fire alarm system were maintained in operational condition and a fire watch protocol was implemented. (See TAG 0430). Severity: 3 Scope: 3	0050	Fire watch was implemented immediately by Administrator and Environmental Service Director once state inspector notified Administrator. As of 4/18, Escalante at the Lakes is off fire watch. All tags in the main riser room our up to date and current. Fire Marshal came out to inspect on 4/18 and notified Administrator that the community can discontinue the fire watch. Fire panel is no longer on trouble or supervisory mode. Going forward, if fire sprinkler system goes down again, Administrator and Environmental Service Director will ensure proper fire watch protocols are in place immediately and communication with local fire authorities are consistent until off fire watch.	04/18/2024
0065 SS= F	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a	0065	• Attached are the caregiver trainings and email stating that we just needed to include the trainings and it would be approved.	03/20/2024

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	combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on record review and interview, the facility failed to ensure initial and/or annual caregiver training was completed, per the requirement for 6 of 10 employees. (Employee #1, #2, #3, #4, #5 and #8). Findings include: Employee #1 (E1) E1 was hired on 12/19/2023 as a Caregiver. E1's file lacked documented evidence of initial caregiving training. Employee #2 (E2) E2 was hired on 08/21/2023 as a Medication Technician. E2's file lacked documented evidence of initial caregiving training. Employee #3 (E3) E3 was hired on 11/06/2023 as the Health Services Director. E3's file lacked documented evidence of initial caregiving training. Employee #4 (E4) E4 was hired on 06/11/2023 as the Executive Director. E4's file lacked documented evidence of initial caregiving training. Employee #5 (E5) E5 was hired on 10/26/2016 as a Caregiver. E5's file lacked documented evidence of initial caregiver training for 2016 and annual caregiving training for 2023. Employee #8 (E8) E8 was hired on 11/13/2023 as the Lifestyle Director. E8's file lacked documented evidence of initial caregiving training. On 03/19/2023 in the morning, the Business Office Manager acknowledged the lack of initial and/or annual caregiving training for E1, E2, E3, E4, E5 and E8. This was a repeat deficiency from the 03/21/23 State Licensure Annual Survey Severity 2 Scope 3			

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0102 SS= D	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 record review and interview, the facility failed to ensure an initial two-step tuberculosis (TB) test was completed for 1 of 10 employees (Employee #3) and an annual TB test and physical examination was completed per the requirement for 1 of 10 employees (Employee #7) Findings include: Employee #3 (E3) E3 was hired on 11/06/2023 as the Health Services Director. E3's file lacked documented evidence of an initial two-step TB test. Employee #7 (E7) E7 was hired on 07/19/2022 as a Medication Technician. Review of E7's file revealed an annual TB screening was last completed on 07/13/2022. E7's file lacked documented evidence of an annual TB test for 2023. E7's file also lacked documentation of a pre-employment physical examination. On 03/19/2024 in the afternoon, the Business Office Manager acknowledged that E3's file lacked documented evidence of an initial two-step TB test, and E7's file lacked documented evidence an annual TB test for 2023 and a pre-employment physical examination. This was a repeat deficiency from the 03/21/23 State Licensure Annual Survey. Severity 2 Scope 1	0102	• E3 and E7 TB results have been updated and are current. • Going forward, Administrator and Business office manager will ensure that all TB testing for employees will be kept track in the employee tickler.	04/13/2024

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0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 employees met the requirements for cardiopulmonary resuscitation (CPR) and first aid training. (Employee #1 and #5) Findings include: Employee #1 (E1) E1 was hired on 12/19/2023 as a Caregiver. E1's record lacked documented evidence of initial first aid and CPR training. Employee #5 (E5) E5 was hired on 10/26/2016 as a Caregiver. E5's file contained a CPR certification which expired on 01/22/2022. E5's record lacked documented evidence of current CPR and first aid training. On 03/19/2024 in the afternoon, the Business Office Manager confirmed the missing first aid and CPR documentation for E1 and E5. Severity: 2 Scope: 1	0106	• E1 and E3 have both went and obtained a current CPR and first aid certification. • Going forward, Administrator and Business office manager have created an Employee Tickler that will show when CPR/first aide are due for all employees. The employee tickler will be reviewed and updated on a regular basis by the Administrator and Business Office Manager. When CPR/first aide are coming due, Administrator and Business office manager will send out reminders to staff members to complete them.	03/20/2024

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were clean and well maintained. Findings include: The following observations were made on 03/19/24: - The sliding closet door in room numbers 153 and 112 were off the sliding wheels and leaning in the closet. - The closet door in room number 164 was lockable from the inside needing a key. - In the dining area of the memory care unit, a drawer had a front panel that was not attached and fell to the floor when trying to be opened. - The outside pathway on the the north side of the building was cluttered with miscellaneous trash. - The front door to room number 256 was broken. - The inside of the bathroom door to room number 254 had a hole in it. - There was a large stainless steel refrigerator in the exterior dumpster area. - Twelve old interior air conditioning vent covers were left next to the storage trailer near the dumpster. - There were excessive weeds throughout the exterior of the facility. On 03/19/24 in the afternoon, the Administrator and the Maintenance Director acknowledged the premises had not been well maintained. This was a repeat deficiency from the 03/21/23 and 08/02/23 surveys. Severity: 2 Scope: 3	0178	The following findings have been corrected or have overseen the corrections by the Environmental Services Director. • Sliding closet doors for room 153 and 112 are now working properly and no longer leaning. • Room 164 now has two doors handles and is no longer lockable from the inside. • Drawer in dining room has been fixed and is no longer falling on the floor when opening. • All areas on the northside have been cleaned/decluttered. • Bathroom door in #254 has been repaired and there is no longer a hole in the door. • Stainless steel refrigerator has been properly hauled away and no longer on the property. • All 12 of the AC unit covers have been hauled away and no longer on the property. • Landscaping company came and due a full deep clean of the entire property. All weeds are gone, bushes trimmed, dead trees removed. • Going forward, Environmental Service Director will have checklist of maintenance items that need to be completed on a regular basis, to ensure various items are repaired on time and clutter is accumulating outside by the dumpsters and walkways.	03/26/2024

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0179 SS= F	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview the facility failed to ensure residents' bedroom windows had window screens. Findings include: On 03/19/24 in the morning, a tour of the facility revealed 23 bedroom windows were without a screen on both the first and second floors of the facility. The Resident in Room 205 reported there had never been a screen on the bedroom window. The resident verbalized wanting a screen on the window so the resident could open the window from time to time. The Resident in Room 208 reported there was no screen on the bedroom window. The resident verbalized not having a screen prevented the resident from being able to open the window for some fresh air. On 03/19/24 in the morning, the Maintenance Director acknowledged the missing screens on the 23 residents' bedroom windows. The Maintenance Director verbalized the majority of the facility's window screens were missing and needed to be replaced. Severity: 2 Scope: 3	0179	• Environmental Service Director contacted Sun Out screen company to give a quote to replace all the missing screens. All screens will be replaced by 5/31/24. • Environmental Service Director and Assistant Environmental Service Director will walk the perimeter of the building on a regular basis to ensure all window screens are on properly. If any window screens come off, Environmental Services Director will ensure they are re-installed properly. • Deposit has been made to start the project to replace all the screens. Contractor stated that all screens would arrive in aprox. 10 day, if not sooner.	05/31/2024
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 03/19/2024, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a.	0255	• Both hot and cold water for the hand washing sink have been repaired and are now working properly. • Black grime in interior has been removed and properly cleaned. • Ventilation hood filters have thoroughly cleaned and are working properly. • Going forward, Culinary Service Director will conduct regular on-going checks to ensure all items in the kitchen are working properly and all scheduled cleanings are also	04/15/2024

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	There was no hot water under pressure at the hand washing sink on the clean side of the dish machine. This impacted one of two hand washing sinks in the kitchen. b. There was no cold water under pressure at the preparation sink. 2. Major Violations: a. There was black grime build-up in the interior. b. The following non-food contact surfaces of equipment were soiled with grease and/or dust build-up: the cook's line ventilation hood filters, behind and on the sides of the equipment on the cook's line, and the internal components of the grill and griddle. c. There was black grime build-up on the Fiber Reinforced Plastic (FRP) wall panels behind the pre-spray sink near the dish machine. d. The floor was soiled with food and debris under the steam table and along the coving tiles throughout the South Memory Care serving kitchen. 3. Equipment and Maintenance Violations: a. The cook's line ventilation hood was not maintained on a frequent basis and was tagged as last professionally cleaned and serviced on 05/31/2023. b. The K-Class and ABC fire extinguishers in the kitchen were not professionally inspected on an annual basis and were tagged as last inspected on 01/04/2023. c. Coving tiles were separating from the wall in the kitchen across from the reach-in units. d. A ceiling light near the dish machine was not covered and had exposed wiring which was not protected by a junction box. This was a repeat deficiency from the 03/21/23 State Licensure Annual Survey. Severity: 2 Scope: 3		happening on a regular basis.	
0430 SS= I	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as	0430	• Since the initial Survey, all fire extinguishers have been inspected and are properly tagged. • Fire panel that is in the front lobby area of the building is now working properly, has the proper tags and is no longer on supervisory or trouble mode. • Fire Sprinkler system is now fully functional, and we are no longer on Fire watch.	04/18/2024

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	applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation, interview, and document review, the facility failed to: 1) Maintain the automatic sprinkler system and the fire alarm system to an operational condition; 2) Follow the local jurisdictional fire department's directives to implement a fire watch program; and 3) Ensure fire extinguishers were inspected annually. Findings include: On 03/19/24 at 10:00 AM, the facility's dry automatic sprinkler (fire suppression) system was observed as not operational. Additionally, the facility's fire alarm (heat detection, smoke detection, audible response, and alarm notification) system was observed to be not operational. On 03/21/24, the Administrator provided the following documentation regarding the events occurring on the day of and after the fire safety system became not operational. -08/17/23: Fire Safety System Vendor Emergency Service Call Findings documented the sprinkler line above Unit 237 was flooded. In the north piping system there were 12 pinhole leaks / corrosion scabs, and in the south piping system there were 14 pinhole leaks / corrosion scabs. The existing compressor for the north system was burnt out and needed to be replaced. The Service Inspector documented being unable to patch enough of the leaks to place the systems back in service. The estimated time for replacement of the piping system and the compressor was six weeks. -08/28/23: The Vendor submitted a proposal to the facility to replace and repair all main sprinkler piping and fittings for the north and south dry systems. The proposal documented the automatic sprinkler system was not functional and was pending replacement. -08/30/23: A fire occurred in the first floor		• During the Initial Survey, Administrator and Environmental Service director was informed the Assited Living community (2nd floor) needed to be on fire watch. Once notified of this, the Administrator and Environmental Service Director created a fire watch sign off sheet for all common areas and resident rooms on the 2nd floor. Each week, the Administrator sent of the weekly fire report to the state inspectors. • As of right now, no fire watch is needed but if the fire sprinkler system was to go down again in the future, the Administrator and Environmental Services Director will ensure all Fire Watch Protocols are in place.	

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	laundry room on 08/30/23 in the early morning. The facility's Incident Report documented the fire alarm was activated on 08/30/23 at 2:15 AM. Staff called 911. The Fire Department came, and the fire was put out by the sprinkler system. According to the fire department, some towels that were on top of the dryer caught fire, the sprinkler system was set off and the fire was put out. Water from the sprinkler system covered all of the walkway on the first floor, dining room, some offices and a little bit into the memory care unit north. The wet fire suppression system was functional in the laundry room, however there was no documented evidence the dry fire suppression system was functional to ensure the facility's second floor common areas, hallways, attic, stairwells, and elevator shaft would have been protected. -09/29/23: The semi-annual inspection documented the automatic sprinkler dry system north and south was not operable (system was down, valves were not open.) - October 2023: The City of Las Vegas Fire Inspector informed the facility they needed to go on a fire watch because the automatic sprinkler system was not functional, and provided specific directives for an immediate 24/7 fire watch. The directive documented, in part: A Fire Watch is a temporary measure intended to ensure continuous and systematic surveillance of a building or portion thereof by one or more qualified individuals for the purpose of identifying and controlling fire hazards, detecting early signs of unwanted fire, raising an alarm of fire, and notifying the Fire Department. Fire Watch personnel shall: 1. Walk the entire building continuously during the entire shift. 2. The person conducting such a fire watch shall be dedicated to that duty only and shall not be used for other duties. 3. Be equipped with, and able to use a bullhorn (or other loud sounding device), flashlight, remote radio, and cellular phone. 4. Be capable of and willing to assist occupants vacating the			

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	building in an emergency situation. 5. Be trained in the use of a portable fire extinguisher. 6. Be instructed in and be familiar with emergency notification and evacuation procedures. -02/13/24: Repair of the automatic sprinkler system began. Date of anticipated completion: 04/24/24. On 03/19/24 at 12:45 PM, the vendor inspector, two contracted technicians, the Administrator, and the Maintenance Director confirmed that the dry automatic sprinkler system (fire suppression system) and the fire alarm system (fire, smoke, and heat detection system) responsible for the second floor main areas, the attic, the stairwells, and the elevator shaft) were not functional since 08/17/23. The Administrator and the Maintenance Director acknowledged the dry automatic sprinkler system was interconnected with the fire alarm system, which could potentially affect all residents' safety in detection, alarm response, and evacuation. On 03/19/24 at 12:45 PM, the contracted vendor indicated the system was additionally put into supervisory mode and was not operational for when the repair project began on 02/13/24. The Administrator and the Maintenance Director verbalized they were aware the automatic sprinkler system was not functioning since 08/17/23, and that a fire occurred in the laundry room, but had not implemented a fire watch program after either one of these incidents. The Administrator and the Maintenance Director acknowledged being made aware of the directive to go on immediate fire watch in October 2024. The Administrator and the Maintenance Director indicated they did not think the fire watch directive needed to be ongoing and did not conduct a fire watch. The Administrator and the Maintenance Director reported the start date of the repair project began on 02/13/24, with the anticipated completion date of 04/24/24. The facility's policy regarding Fire Watch Requirements (undated) documented: The Fire Watch shall consist of a minimum of			

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	one person per shift each per day qualified persons who shall have the responsibility for the continuous patrol of the entire premises (which includes but not limited to attics, crawl spaces, storage rooms, resident rooms, employee break rooms and concealed areas) for the purpose of detecting fire and transmitting an immediate alarm to the building occupants and to the Fire Department. Assigned Fire Watch personnel shall: -Notify local Fire Department and Authority Having Jurisdiction of Fire Watch. -Be thoroughly familiar with the area they are patrolling (including knowing where the manual fire alarm stations and fire protection equipment is located and knowing how to properly use them). -Perform patrol operations according to instructions from Management. -Patrol their designated area at least once each half hour and be able to immediately relay emergency information. -Make reports as instructed. A written record of patrol rounds and any significant information shall be recorded in a log book provided by Management. -Relay any special orders or pertinent information to relief personnel. -Remain on duty until properly relieved. There was no documented evidence the facility implemented a Fire Watch protocol per facility policy as of 08/17/23 when the facility's dry automatic sprinkler system and fire alarm became not operational, on 08/30/23 after the facility identified a fire in the laundry room, or any other time prior to the survey conducted by the Bureau of Health Care Quality and Compliance on 03/19/24. Additionally, there was no documented evidence the facility attempted repair and replacement of the dry automatic sprinkler and fire alarm system until 02/13/24. Finally, there was no evidence the facility followed the directive by the City of Las Vegas Fire Authority. The facility's fire extinguishers were last inspected on 01/04/23. On 03/17/24 in the morning, the Maintenance Director confirmed the fire extinguishers were last inspected in			

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

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	January of 2023. The Maintenance Director acknowledged the fire extinguishers should be inspected annually. Additionally, a State Fire Marshal referral was made on 03/22/24. Severity: 3 Scope: 3			
0593 SS= F	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on observation and interview, the facility failed to ensure the environment was safe for residents within the memory care unit. Findings include: On 03/19/24 in the morning, a door labeled with "Danger High Voltage" located in the memory care unit was observed to be unlocked and accessible to residents. Inside the room was electrical panels with pull switches to turn the power on and off within the unit. On 03/19/24 in the morning, the Administrator acknowledged the door should have been locked and made inaccessible to residents. On 03/19/24 in the morning, located in the memory care unit was a double door leading from a dining/activity area to an outside courtyard. When opened, the door alarmed and when the door closed the alarm shut off. When exiting this door it was observed the door was locked from the outside preventing anyone from reentering the facility. This left the possibility of a resident exiting the building and prevented them from being able to return without staff knowledge the alarm had sounded, but turned itself off once the door was closed. On 03/19/24 in the morning the Administrator and the Maintenance Director acknowledged the unlocked electrical room and the double door leading to the outside courtyard was a safety concern. Severity: 2 Scope: 3	0593	• High Voltage door in MC north was unlocked. Administrator and Environmental Services Director immediately got the key and locked the door securely. Door was pulled on multiple times to ensure the door was actually locked. • Environmental Services Director and Administrator walk the MC north Hallway on a regular basis and pull the high voltage door to ensure the door is closed and properly locked. • MC North doors leading to the secured patio area have been unlocked from the outside going in. By doing this, it ensures the safety of our residents if they were to go on the secured patio, they would still have a way back. • The MC north Patio doors will remain unlocked on a ongoing basis and the Environmental Services Director will ensure the MC north patio doors are unlocked from both the inside and outside as he is doing his regular rounds of the building.	03/20/2024
0690	Residents Requiring Use of Oxygen - NAC	0690	• Based on Surveyors findings, the	03/19/202

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SS= F	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 resident. Inspector Comments: Based on observation and interview, the facility failed to ensure Oxygen tanks were secured. Findings include: On 03/19/24 in the morning, in room number 153, were two Oxygen tanks unsecured on the floor near the resident's closet. On 03/19/24 in the morning, a Caregiver acknowledged the Oxygen tanks		Health Service Director immediately placed all oxygen tanks in rooms 204 and 153 in secured crates. Completion date 3/19/24 • The Health Service Director held an all staff meeting on 3/26/2024 to educate all Health Service staff on Oxygen safety. Completion date 3/26/24 and ongoing. • The Health Service Director, RCC and Memory Care Director to complete frequent audits to both staff and all like residents are maintaining storing oxygen safely. Completion date 3/25/24 and ongoing.	4

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	were not secured and should have been. On 03/19/24 in the morning, in room number 204, there were 13 Oxygen tanks unsecured on the floor across from the resident's bathroom. On 03/19/24 in the morning, the Maintenance Director acknowledged the Oxygen tanks were not secured and verbalized they should have been. Severity: 2 Scope: 3			
0860 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he or she requires. (b) Monitor the ability of the resident to care for his or her own health conditions and document in writing any significant change in his or her ability to care for those conditions. Inspector Comments: Based on interview, record review and document review, the facility failed to 1) follow their policy to complete a fall risk evaluation and 2) complete an incident report following a fall with injury for 1 of 17 Residents (Resident #16). Findings include: Resident #16 (R16) was admitted on 11/07/23 with dementia and generalized weakness. R16 was discharged to the hospital on 12/24/23. Progress note dated 11/07/23 documented R16 was a fall risk. Incident reports dated 12/02/23, 12/04/23 and 12/17/23, revealed R16 had unwitnessed falls. Progress note dated 12/24/23 at 12:52 AM, documented, R16 had an unwitnessed fall in their bedroom and got a fractured nose. R16 was transported to the hospital. There was no documentation an incident report was created for R16 after the fall with injury on 12/24/23. Facility policy on Fall Risk Evaluation documented residents who are fall risks must be evaluated using the Morse Fall Scale to identify residents at high risk for falls and place resident into one of three	0860	• A fall prevention and recovery in-service were completed on 3/22/24 and 3/26/24 by regional Nurse consultant and Health Service Director. • Health Service Director to complete an all-staff in-service on Frontier's policies and procedures, regarding incident reports and how to complete incident reports. Completed on 4/29/24 and ongoing. • Health Services Director, RCC, and Memory Care Director will review according to policy, audit all incident reports, alert charting, and 24-hour notes. A 24-hour binder will be initiated for all units. Completion on 4/24/24 and ongoing. • Heath Service Director, RCC, and Memory Care Director to ensure all like residents has a fall risk assessment and service plan. Completed on 3/22/24 and ongoing. • Will update logs and review for trends in incidents. High-Risk residents will be included in a weekly interdisciplinary High-Risk meeting to identify solutions and monitor progress. Completed on 4/22/24 and ongoing	03/22/2024

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	fall categories. Intervention strategies are provided in the program based on assessed level of fall risk. Review of R16's medical record did not show documentation a Morse Fall Scale evaluation was completed upon admission or after any subsequent falls. On 03/19/24 in the afternoon, the Administrator and Health Services Director could not locate an incident report of R16's fall and indicated not knowing if an incident report was created. On 03/22/24 at 2:30 PM, the Administrator indicated being unaware if a Morse Scale Fall evaluation was ever conducted for R16, and confirmed there was no documentation of a Morse fall risk evaluation completed for R16. Severity: 2 Scope: 1			

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a medication review was completed every six months for 1 of 17 residents (Resident #12). Findings include: Resident #12 (R12) R12 was admitted on 04/09/22. R12's file lacked documented evidence that a medication review was completed every six months. R12's file lacked documented evidence of a medication review for calendar years 2023 and 2024. On 03/19/24 in the afternoon, E4 acknowledged medication reviews had not been completed every six months for R12. Severity: 2 Scope: 1	0870	• Based on the states Findings during survey, the Health Services Director and Administrator immediately reviewed and signed the six-month medication reviews submitted by the pharmacy and updated each residents' files. completion date 07/24 and ongoing. • To maintain future compliance, the Health Services Director ensure the 6 months medication are reviewed and signed by the administrator and Health Service Director in a timely manner. Completion Date 07/24 and ongoing. • To ensure future compliance with all like residents, the Health Services Director will create a spreadsheet to keep track of next due medication review, so they are completed in a timely manner. Completion date 4/30/24	07/01/2024
0874 SS= D	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver	0874	• Based on the state's findings during survey, the Health Service Director and Administrator immediately reviewed, signed and faxed over	07/24/2024

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	and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the facility failed to ensure pharmacy reports listing medication concerns were communicated to the residents' physicians and reviewed by the Administrator for 2 of 17 sampled residents (Resident #11 and #1). Resident #11 (R11) R11 was admitted on 03/15/22, with diagnosis including high blood pressure. R11's pharmacy review dated 01/31/24, documented Caution: patient on multiple blood pressure medications. Please watch patient for excessive dizziness to prevent falls and fractures. R11's pharmacy review was not initialed by the Administrator to indicate the Administrator had reviewed it. There was no documented evidence the physician was notified of the Pharmacist's cautionary statement. Resident #1 (R1) R1 was admitted to the facility on 07/31/22 with diagnoses including chronic kidney disease, lower back pain, and major depressive disorder. The Pharmacy Report dated 01/31/24 documented, Caution: Patient on pain and insomnia medications. Please watch patient for excessive drowsiness to prevent falls and fractures. There was no documentation the physician was notified of the pharmacy's cautionary statement. There was no documentation the Administrator reviewed and initialed the Pharmacy Report. On 03/19/24 at 12:00 PM, the Health Services Director acknowledged the Pharmacy Reports for R11 and R1 were not forwarded to the residents' respective physicians for review and were not reviewed by the Administrator. On 03/19/24		copies of the medication reviews with recommendations for listed residents and all like residents 3/20/24 to providers to e reviewed within a timely manner. Completion date 3/20/24 and ongoing. • The Health Services Director and Administrator will ensure next due medication reviews in July 2024 with recommendations are reviewed, signed and forwarded to be reviewed by each assigned providers within a timely manner. Completion will be on 07/24 and ongoing. • To ensure future compliance with all like residents, the Health Services Director will create a spreadsheet to keep track of next due medication review so they are completed in a timely manner. Completion on 4/30/24 and ongoing	

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	at 5:15 PM, the Administrator acknowledged not reviewing the Pharmacy Reports. The Health Services Director and the Administrator confirmed there was no system in place by the facility to ensure results of the pharmacy were reviewed and forwarded to the physician for notification. Severity: 2 Scope: 1			
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on interview and record review, the facility failed to provide ultimate user agreements authorizing the facility to administer medication for 3 of 17 sampled residents (Resident #1, #8, and #9). Findings include: Resident #1 (R1) R1 was admitted to the facility on 07/31/22 with diagnoses including chronic kidney disease, lower back pain, and hypertension. A review of R1's file revealed the facility assisted in the administration of medication for R1. R1's file lacked documentation of an ultimate user agreement authorizing the facility to administer medication. Resident #8 (R8) R8 was admitted on 09/14/23, with diagnoses including encephalopathy and diabetes. On 03/19/24 in the morning, a review of R8's medications revealed the facility assisted with R8's medications. R8's file lacked documented evidence of an ultimate user agreement authorizing the facility to administer medication. Resident #9 (R9) R9	0876	• Based on the states findings during survey, the Health Services Director got completed and signed Ultimate User Agreements for each listed residents and updated chart and files. Completion on 4/18/24 • To ensure future compliance, the Ultimate User Agreements has been added to all admission paperwork. Completed on 4/18/24 and ongoing.	04/18/2024

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	was admitted on 09/14/23, with diagnoses including encephalopathy and transient cerebral ischemic attack. On 03/19/24 in the morning, a review of R9's medications revealed the facility assisted with R9's medications. R9's file lacked documented evidence of an ultimate user agreement authorizing the facility to administer medication. On 03/19/24 at 5:00 PM, the Health Services Director acknowledged Ultimate User Agreements were not completed and signed for R1, R8, and R9. 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	• To ensure future compliance, the community has partnered with the community pharmacy to complete 6-month cart audits. Completion date will be 5/15/24 and ongoing. • In addition to the audits, the community has initiated cycle refills with the community pharmacy for all like residents. • The Health Services Director to educate all current and future medication technicians on procedures of medication refill request, to ensure all needed medications are available in the community as per doctor's orders. Completion date will be 4/29/2024 and ongoing.	05/15/2024

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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 record review and interview, the facility failed to ensure medications were onsite and available as prescribed for 1 of 17 sampled residents (Resident #14). Findings include: Resident #14 (R14) R14 was admitted on 09/14/23, with diagnoses including encephalopathy and diabetes. A physician's order dated 04/01/23 and the March 2024 Medication Administration Record (MAR), documented Azelastine 0.1 percent, one spray in each nostril as needed for allergies max two doses in 24 hours and Immodium 2 milligrams (mg), take one tablet by mouth before a meal for upset stomach two times a day as needed. R14's Azelastine 0.1 percent nasal spray and Immodium 2 mg were not on site and available as prescribed. On 03/19/24 in the morning, the Medication Technician acknowledged the medications were not on site and should have been onsite and available. This was a repeat deficiency from the 03/21/23 and 08/02/23 surveys. Severity: 2 Scope: 1			
0895	Administration of Medication Maintenance -	0895	• The health Services Director	04/29/202

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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
SS= D	NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on record review and interview, the facility failed to ensure a medication was documented on the Medication Administration Record (MAR) for 1 of 17 sampled residents (Resident # 8). Findings include: Resident #8 (R8) R8 was admitted on 09/14/23, with diagnoses including encephalopathy and diabetes. A physician's order dated 03/16/24, documented a change order for Bisacodyl 5 milligrams (mg), from take one tablet by mouth every day to take two tablets by mouth every day. Bisacodyl 5 mg was not listed on the electronic MAR and there was no documented evidence the new order to take two tablets by mouth every day was on the electronic or paper MAR. On 03/19/24 in the morning, the		immediately audited the residents EMAR and found the order in pending review orders, reviewed it and updated the residents EMAR. Completion date 3/20/24 • Based on the states findings during survey, the Health Services Director will assign and train a second party, on reviewing and approving new medication orders received, per policy and regulations to ensure future compliance. • The Health Services Director, RCC, Memory Care Director to complete random Medication Technician medication administration audits to ensure compliance. Completion on 4/24/24 and ongoing. • The Health Services Director to educate all current and future medication technicians of the 5R's of medication administration. Completion will be on 4/29/24 and ongoing.	4

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	Medication Technician reported R8 had received the medication per the physician's order to take two tablets by mouth every day and acknowledged the current order for Bisacodyl was not documented on the MAR and should have been. Severity: 2 Scope: 1			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were secure. Findings include: On 03/19/24 in the afternoon, there was a bottle of Rolaids and Pepto Bismol unsecured on the bedroom shelf in Room #254 (Resident #10). The resident, who self-administered medications, was not present in the room and the door was left open and unsecured. On 03/19/24 in the afternoon, the Caregiver confirmed the medications were unsecured and the door should have been locked if the resident was not present. On 03/19/24 in the morning, in room number 164, located in the memory care unit, was an unlocked walk-in closet	0920	• Based on the states findings during the survey, the health services director immediately audited each listed rooms on 3/19/24 and removed found items and secured them based on regulations. Completion date 3/19/24 • To ensure future compliance, the Health Services Director, RCC and Memory Care Director will perform routine room audits to ensure medications are stored safely per regulations. Completion will be on 5/17/24 and ongoing. • Community to provide routine education to staff and families on regulations pertaining to NAC 449.2748 to ensure future compliance. Completion will be on 6/10/2024	03/19/2024

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	containing Metamucil, Pepto Bismol, Mineral Oil, and five bottles of Magnesium Citrate. On 03/19/24 in the morning, in room number 145, located in the memory care unit, was a box containing Latanoprost ophthalmic eye drops labeled with a pharmacy prescription for the resident residing in the room. On 03/19/24 in the morning, a Medication Technician confirmed the medications were unsecured and should be have been locked in the medication room. On 03/19/24 at 5:00 PM, the Health Services Director and the Administrator indicated all medications should have been secured with a lock for safety, and medications for residents who self-administered medication should have been secured in the resident's room. Severity: 2 Scope: 3			
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to provide tuberculin (TB) testing results for 3 of 17 sampled residents, per the requirement (Resident #2, #5, and #13). Findings include: Resident #2 (R2) R2 was admitted to the facility on 03/29/19 with diagnoses including stage 3 chronic kidney disease and dyslipidemia. There was no documented evidence of annual TB testing for R2. The most recent documented TB	0936	• To ensure continued compliance as per regulations, the Health Services Director completed annual TB screening for R#2 and R#5. Completion date 4/4/24 • Health Service Director to complete annual TB screening for each resident to ensure compliance by utilizing the Nevada Tuberculosis Prevention, Control and Elimination program: Healthcare Facilites Tuberculosis Screening Manual. Completion will be on 6/1/24. • Health Service Director to create a tracking system to ensure future compliance. Completion on 4/19/24 and ongoing. • Resident #2 AND #5 TB testing has been uploaded. Resident #13 has passed away.	06/01/2024

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	testing was dated 02/01/23, negative results. Resident #5 (R5) R5 was admitted to the facility on 11/10/22 with diagnoses including diabetes mellitus and hypertension. R5 had a positive Quantiferon TB test on 09/14/22 and an X-ray 10/05/22. There was no documented evidence of annual signs and symptoms of TB checks for R5. Resident #13 (R13) R13 was admitted to the facility on 03/15/22 with diagnoses including gout, dementia, and hypertension. R13's file lacked documented evidence of an initial two-step TB test. R13's file contained a negative chest x-ray result dated 02/07/24, but lacked documented evidence of positive TB result prior to the x-ray. On 03/20/24 at 11:30 AM, the Health Services Director acknowledged the files for R2, R5, and R13 lacked documented TB testing, per the requirement. Severity: 2 Scope: 1			

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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 sharp items were not accessible to residents. Findings include: On 03/19/24 in the morning, in room number 145, located in the memory care unit, fingernail clippers were observed in a basket near the resident's dresser. On 03/19/24 in the morning, in room number 137, located in the memory care unit, tweezers were observed laying on a bedside stand near the resident's bed. On 03/19/24 in the morning, a Caregiver acknowledged the fingernail clippers and tweezers should not have been accessible to residents. This was a repeat deficiency from the 03/21/23 State Licensure Annual Survey. Severity: 2 Scope: 3	0994	• Based on findings during survey, the Health Services Director immediately removed listed items and placed them in a secured area to maintain compliance. Completed on 3/19/24. • To ensure future compliance, the Health Services Director, RCC and Memory Care Director to complete routine room audits for all like residents to ensure safety. Completion will be on 5/8/24 and ongoing. • The Caregiver checklist has been revised and locking of supplies has been added as part of the education/training that will be provided to all current employees annually and all new employees. Completion will be on 5/17/24 and ongoing. • Community to provide ongoing education to staff and families to ensure future compliance. Completion date will be 6/10/2024.	03/19/2024

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

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0995 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: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure a common area courtyard for a memory care unit was secured. On 03/19/24 in the morning, a gate located in the memory care unit courtyard was unlocked. A path leading from this gate circled around the northside of the building and ended in the open parking lot. No staff were present. On 03/19/24 in the morning a Maintenance Assistant acknowledged the gate was unlocked. On 03/19/24 in the afternoon, the Maintenance Director verbalized the gate should have been locked. Severity: 2 Scope: 3	0995	• Based on findings during the survey, the Health Services Director immediately removed items and placed them in secured storage. Completion 3/19/24 • To ensure future compliance, the Health Services Director, RCC and Memory Care Director to complete routine room audits on like residents to ensure resident safety. Completion will be on 6/30/24 and ongoing. • Health Services Director to educate all staff the importance of placing listed items in secured storage. Completion date will be 4/29/24.	03/19/2024

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0999 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: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were secured. Findings include: On 03/19/24 in the morning, in room number 137, located in the memory care unit, was observed mouthwash, poligrip Medi-Honey gel, pain relief gel, and cologne. On 03/19/24 in the morning, in room number 164, located in the memory care unit, was observed Aquaphor, dermaseptine, mouthwash and Purell hand sanitizer in the bathroom. On 03/19/24 in the morning, an unlocked cupboard located in the memory care unit, in an activity area near the medication room contained a bottle of Ultra Deluxe dishsoap and a container of Lysol wipes. On 03/19/24 in the morning, a Caregiver acknowledged these substances should not have been available to residents. On 03/12/24 in the afternoon, the Administrator acknowledged toxic substances should have been secured and not available to residents. Severity: 2 Scope: 3	0999	• On 3/20/24, we were notified by the surveyor that there we toxic substances that we failed to secure. Shortly after being notified, the Health Services Director, Environmental Services Director and Administrator took the items mentioned in 137 and re-located them to a locked/secured area. • the unlocked cupboard in the Activity area has been locked the Deluxe Dish soap and Lysol is no longer available to the residents. • As the surveyor's brought this to our attention, going forward each shift will walk into each room and ensure all toxic substances are locked/ secured and not easily accessible to the residents.	03/20/2024
1540 SS= D	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once	1540	• All employee Culture competencies have been completed and up to date. • Going forward, the Administrator and the Business Office Manger have created an employee tickler to help keep track of various employee trainings that are due, including culture competency.	04/16/2024

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	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 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			

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	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 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			

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	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 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			

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	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 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			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESCALANTE AT THE LAKES	**2620 LAKE SAHARA DRIVE, LAS VEGAS, NEVADA ,89117**

(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
	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 record review and interview, the facility failed to ensure 3 of 10 employees received cultural competency training (Employee #1, #3 and #8). Findings include: Employee #1 (E1) E1 was hired on 12/19/2023 as a Caregiver. E1's file lacked documented evidence of cultural competency training. Employee #3 (E3) E3 was hired on 11/06/2023 as the Health Services Director. E3's file lacked documented evidence of cultural competency training. Employee #8 (E8) E8 was hired on 11/13/2023 as the Lifestyle Director. E8's file lacked documented evidence of cultural competency training. On 03/19/2024 in the afternoon, the Business Office Manager acknowledged E1, E3 and E8 had not completed cultural competency training. This was a repeat deficiency from the 03/21/23 State Licensure Annual Survey. Severity: 2 Scope: 1			
1830 SS= D	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for	1830	• Business office manager has her infection control completed and it is uploaded. Administrator is currently working to complete the infection control training and will have it completed by 5/3/24.	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/22/2024**

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	Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control designees completed 15 hours of infection control training (Employee #4 and #12). Findings include: Employee #4 (E4) E4 was hired as the Administrator. E4's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. Employee #12 (E12) E12 was hired as the Business Office Manager. E12's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. On 03/19/24 in the afternoon, E4 confirmed E4 was the primary infection control program designee and E12 was the secondary infection control designee. E4 was unable to provide documented evidence the required infection control and prevention training had been completed for E4 and E12. Severity: 2 Scope: 1		• Administrator and Business office manager have added Infection control training to the employee tickler. If one of us would leave, we would than re-assign the infection control training to the new hire.	