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 _____	**11/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON ASSISTED LIVING LLC	**550 NORTH SHERMAN ST., FALLON, NEVADA ,89406**

(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 a State Licensure annual grading and complaint investigation survey conducted at your facility on 11/20/2024. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 37 Residential Facility for Group beds for elderly or disabled persons with assisted living services, Category II residents. The census at the time of the survey was 29. Ten resident files and ten employee files were reviewed. The facility received a grade of A. There were two complaints investigated: Complaint #NV00072720 with the allegation a resident with a diagnosis of dementia was not adequately assessed for placement was substantiated (See Tag Y1700). The following allegations could not be substantiated due to a lack of evidence: Allegation #2: A resident's responsible party was not notified of resident change in condition. Allegation #3: A resident was left in soiled clothing for extended periods of time. Allegation #4: A resident was not assisted with activities of daily living to include bathing or dressing. Allegation #5: A resident had offensive body odors as a result of facility negligence. Allegation #6: The facility provided an inappropriate level of care to a resident. The investigation into the allegations included: Observation of residents in the common areas of the facility, resident interactions with staff, and housekeeping activities. Interviews with one resident and the facility administrator. Review of 10 resident records including the resident of interest, monthly pharmacy reviews, medication administration records, individualized service plans, placement determinations, activities of daily living assessments, physicals, and hospice records. Review of 10 employee records	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: HEATHER DEITRICK Title: Administrator Date: 03/18/2025

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	including caregiver training, cultural competency training and elder abuse prevention training. Review of grievance logs, incident reports, and the facility abuse policy. Complaint #NV00071896 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: A resident was left in soiled clothing for extended periods of time. Allegation #2: A resident was not assisted with activities of daily living to include bathing or dressing. Allegation #3: A resident had offensive body odors as a result of facility negligence. The investigation into the allegations included: Observation of residents in the common areas of the facility, resident interactions with staff, and housekeeping activities. Interviews with one resident and the facility administrator. Review of 10 resident records including the resident of interest, monthly pharmacy reviews, medication administration records, individualized service plans, placement determinations, activities of daily living assessments, physicals, and hospice records. Review of 10 employee records including caregiver training, cultural competency training and elder abuse prevention training. Review of grievance logs, incident reports, and the facility 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.			

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0051 SS= B	Administrator's Responsiblities - Designation - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. Inspector Comments: Based on observation and interview, the facility failed to designate in writing one or more employees to oversee the facility during the Administrator's absence and post the names in a public place within the facility. Findings include: On 11/20/2024 at 10:48 AM, a posting documented the facility designee was the "Med Tech on duty." On 11/20/2024 at 10:48 AM, the Administrator confirmed the posting lacked the name of a designee, verbalized the facility did not have a specific designee, and explained the designee changed depending on who was working that day. Severity: 1 Scope: 2	0051	1) How will you correct the specific finding (s) stated in the Statement of Deficiencies? Administrator will designate in writing the employee(s) to oversee the facility during the Administrator's absence and post the names in a public place within the facility. 2) What measures or systematic changes(s) will be put into place to ensure the deficient practice does not recur. Administrator will post the name(s) in a public place of who oversees facility in the absence of the administrator. 3) How the corrective action will be monitored to ensure the deficient will not recur. Administrator and or designee to monitor posted employees that oversee facility. 4) The title of the person responsible for ensuring the plan of correction is implemented. Administrator and/or Resident Service Director. 5)The date the corrective action will be implemented. 11/22/2024	03/18/2025

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0250 SS= D	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure a personal beverage was not located in the food prep area of the kitchen with the potential to cross contaminate with the residents' food. Findings include: On 11/20/2024 at 9:53 AM, a personal bottle of water was located in the food prep area of the kitchen. The bottle had been opened and was not full. On 11/20/2024 at 9:53 AM, the Dietary Cook confirmed the bottle of water was a personal beverage located in the food prep area and should not have been there. Severity: 2 Scope: 1	0250	1) How you will correct the specific finding (s) stated in the Statement of deficiencies. Dietary manage will in-service dietary staff on no personal drink/food are to be in food prep area. 2) What measures or systematic changes will be put into place to ensure the deficient practice does not recur. Dietary manager and/or designee to monitor food prep area. 3)How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Dietary Manager to monitor kitchen prep area for no personal items. 4) The Title of the person responsible for ensuring the correction is implemented. Dietary manager and/or designee. 5)The date the corrective action will be implemented. 12/6/2024	03/18/2025

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0252 SS= D	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure food was properly stored in the kitchen. Findings include: On 11/20/2024 at 9:53 AM, during a tour of the kitchen, a bag of tortillas was labeled with an open date of 11/12. On 11/20/2024 at 9:53 AM, a Dietary Cook verbalized food without an expiration date was to be discarded after three days. The Dietary Cook confirmed the tortillas should have been discarded. The facility policy titled "Use and Storage of Foods," last revised 02/2014, documented food without a designated expiration date would be discarded after three days. Severity: 2 Scope: 1	0252	1) How will you correct the specific finding (s) stated in the Statement of Deficiencies. Dietary manager to in-service kitchen staff on facility policy " Use and storage of foods" 2) What measures or systematic changes will be put into place to ensure the deficient practice does not recur. Dietary manager and or designee will monitor food storage for out-of-date food. 3) How the corrective action will be monitored to ensure the deficient practice will not recur. On-going monitoring of food storage area. 4) The title of the person(s) responsible for ensuring the plan of correction is implemented. Dietary manager and/or designee. 5) The date the corrective action will be implemented. 12/6/2024	03/18/2025
1600 SS= D	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 adapted pursuant to subparagraph (1) of	1600	1)How you will correct the specific finding(s) stated in the Statement of deficiencies. Preferred name/pronoun will be added to residents' record. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur. During admission residents' preference will be noted and put in residents' record. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Residents will have their record updated to reflect preferences. 4) The title of the person(s) responsible for ensuring the plan of correction is implemented. Administrator and Resident Service Director 5) The date the corrective action will be completed. 3/18/2025	03/18/2025

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	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 read or speak English or any other			

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	language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on record review and interview, the facility failed to ensure resident records included the resident's preferred name and pronoun and in accordance with his or her gender identity or expression. Finding include: On 11/20/2024 at 3:30 PM, the Administrator confirmed the facility had not developed a method to include a resident's preferred name and pronoun in accordance with the resident's gender identity or expression in the resident record. Severity: 2 Scope: 1			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical 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	1700	1) How will you correct the specific finding (s) stated in the Statement of Deficiencies. Audits on residents' Annual assessments will be conducted. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur. Resident Service Director will monitor annual assessments utilizing a compliance worksheet to ensure they are completed on time. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Compliance worksheet will be used to monitor the corrective action. 4) The title of the person responsible for ensuring the plan of correction is implemented. Resident Service Director 5) The date the corrective action will be completed. 1/1/2025	03/18/2025

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	has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an annual Standard Physician Assessment and Placement Determination for 1 of 10 sampled residents (Resident #1). Findings include: Resident #1 was admitted to the facility on 05/23/2024, with a diagnosis of vascular dementia. Discharged 09/01/2024. Resident #1's clinical record documented a Standard Physician Placement Determination dated 05/18/2022, but lacked an annual Standard Placement Determination completed in 2024. On 11/20/2024 at 2:49 PM, the Administrator verbalized Physician placement determinations were completed for residents with a dementia diagnosis to determine if a higher level of care was needed for the resident. The Administrator confirmed Resident #1 had a diagnosis of dementia and Resident #1's clinical record lacked an annual physician placement determination completed after 2022. Severity: 2 Scope: 1 Complaint			

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