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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**10/27/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR PREMIER RESIDENCES OF RENO	**3201 PLUMAS STREET, RENO, NEVADA ,89509**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted at your facility on 10/27/21. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 41 Residential Facility for Group beds for elderly and disabled persons with assisted living services, Category II residents. The census at the time of the survey was 32. Ten resident files were reviewed and eight employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. One complaint was investigated. Complaint #NV00064754 with the following allegations could not be substantiated: Allegation #1: The facility did not have a Registered Nurse could not be substantiated, because the facility did not have to have a Registered Nurse on staff. Allegation #2: The facility was understaffed could not be substantiated due to a lack of evidence. Allegation #3: Call lights were not being answered timely could not be substantiated due to a lack of evidence. Allegation #4: A resident fell and remained in pain for two days could not be substantiated due to a lack of evidence. Allegation #5: The facility had medication	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: PATRICK WARD Title: Executive Director Date: 12/23/2021

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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	errors could not be substantiated due to a lack of evidence. The investigation into the allegations included the following: Observations of employee interactions with residents, a tour of the facility to include resident rooms, and call light system at reception desk. Interviews were conducted with a Medical Technician, Lead Resident Assistant, Director of Resident Care, Dining Room Supervisor, and seven residents. Document review included ten resident records, staffing schedules, employee records, Medication Administration Records, and policies. 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:			
0072 SS= D	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of	0072	1) How Facility will identify - when in hiring process we will make sure there is no gap between trainings and Re-certifications. 2) What measures will be put in place - We will use Tickler File to monitor - see example attached document 3) How facility will monitor - Business office Manager-HR Coordinator will use tickler file for employee training for accuracy 4) Responsible party for monitoring compliance - Business Office Manager- HR Coordinator / designee 5) Anticipated date of correction - 11/12/2021	11/12/2021

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	NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 1 of 8 employees completed the required 8 hours of annual medication management training on a timely basis (Employee #6). Findings include: Employee #6 Employee #6 was hired as the Director of Resident Care with a start date of 09/27/21. Employee #6's employee file documented sixteen hours of initial Medication Management training dated 12/05/19, with an expiration date of 12/05/20. Employee #6's employee file documented an annual Medication Management training dated 01/27/21. There was a gap of 43 days between the intial and annual training. On 10/27/21 at 1:56 PM, the Director of Resident Care confirmed there was a gap in medication management training for Employee #6 and the employee was required to re-take the initial Medication Management training due to the gap in certification. Severity: 2 Scope: 1			
0102 SS= F	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 employee file review, document review and interview, the facility failed to ensure a tuberculosis (TB) screening was completed within the required timeframe for 4 of 8 employees (Employee #1, #3, #4 and #6). Findings include: Employee #1 Employee #1 was hired as a Lead Medication Technician with a start date of 08/04/21. Employee #1's employee file documented an x-ray read negative for a positive TB test dated 07/27/21 and lacked documented evidence	0102	1) How facility will identify - At Pre-Hire all employee's will have all completed TB testing by onboarding new employee's and additional testing will take place within 30 days of employment when needed. When a new team member is able to show proof of a positive TB skin test they will be able to do chest x-ray and then yearly we will complete a sign and symptoms questionnaire form for that employee. See attached document 2) What measures will be put into place - Tickler File see example document 3) How facility will monitor - Business office manager-HR Coordinator will manage Tickler file 4) Responsible party for monitoring compliance - Business Office Manager-HR Coordinator 5) Anticipated date of correction - #6 completed 10/28/2021 - #1,3,4 no longer	10/28/2021

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	of a TB signs and symptoms questionnaire upon employment. Employee #1's employee file lacked documented evidence of a positive TB test. Employee #3 Employee #3 was hired as a Resident Assistant with a start date of 08/04/21. Employee #3's employee file documented the following: - a first step TB test given on 07/13/21 and read negative on 07/15/21. - a negative QuaniFERON lab test dated 09/10/21. Employee #3's employee file lacked documented evidence of completing TB testing before the start of employment and working with residents. Employee #4 was hired as a Resident Assistant with a start date of 06/23/21. Employee #4's employee file documented the following: - a TB test given on 06/04/21 and not read. - a TB test given on 06/18/21 and read negative on 06/21/21. - a TB test given on 07/21/21 and read negative on 07/23/21. Employee #4 lacked documented evidence of completing TB testing before the start of employment and working with residents. Employee #6 was hired as the Director of Resident Care with a start date of 09/27/21. Employee #6's employee file documented a positive QuantiFERON lab test dated 04/14/21. Employee #6's employee file lacked documented evidence of a chest x-ray to rule out TB and a completed TB signs and symptoms questionnaire upon employment, before working with residents. On 10/27/21 at 11:42 AM, the Business Office Manager confirmed the TB findings for Employee #1, #3, #4 and #6 and verbalized the lack of completing the TB employee screening posed a risk to residents. Severity: 2 Scope: 3		employed at this facility.	

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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 employee personnel file review, document review and interview, the facility failed to ensure 2 of 8 employees (Employee #2 and #5) completed cardiopulmonary resuscitation (CPR) and first aid training within 30 days of employment. Findings include: Employee #2 Employee #2 was hired as a Resident Assistant with a start date of 05/11/21. Employee #2's personnel file documented CPR and first aid training, dated 08/04/21. The CPR and first aid training was completed 53 days late. Employee #5 Employee #5 was hired as a Resident Assistant with a start date of 07/06/21. Employee #5's personnel file documented CPR and first aid training dated 08/27/21. The CPR and first aid training was completed 21 days late. On 10/27/21 at 1:54 PM, the Business Office Manager confirmed Employee #2's and #5's CPR and first aid training was not completed within the required 30 days of employment and verbalized both employees had been regularly scheduled to work with residents. Severity: 2 Scope: 1	0106	1) How facility will identify - Using Tickler File for all Employee's - see sample attached 2) What measures will be put into place - Tickler File is now used to monitor 3) How facility will monitor - Through the use of Tickler File and employee file monthly audits 4) Responsible party for monitoring compliance - Business Office Manager-HR Coordinator / Designee 5) Anticipated date of correction - 10/28/2021	10/28/2021

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0172 SS= D	Health And Sanitation-Garbage - NAC 449.209 Health and sanitation. (NRS 449.0302) 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure garbage dumpsters were covered. Findings include: On 10/27/21 at 10:10 AM, three large garbage dumpsters were lined up to the left, outside the back door of the kitchen. Each dumpster's lid was in the open position and the dumpsters were uncovered. On 10/27/21 at 10:17 AM, the Dining Room Manager confirmed the three dumpsters were opened and uncovered. The Dining Room Manager verbalized the Dining Room Manager had never closed the lids on the dumpsters and had not been aware who was responsible to keep the dumpsters closed. The facility policy titled, "Dumpster Safety," effective date 10/01/18, documented garbage dumpsters were to be maintained with their lids closed. Severity: 2 Scope: 1	0172	1) How facility will identify - Daily monitoring by management 2) What measures will be put into place - In-Service Training completed 12/01/2021 - 12/04/2021 on the use and safety of our dumpsters see training in-service document attached. Sign posted in select locations to remind employee's. See attachment 3) How facility will monitor - Daily checks and Weekly Sanitation Audits - see attachment 4) Responsible party for monitoring compliance - Food and Beverage Director/ Designee 5) Anticipated date of correction - 10/28/2021	10/28/2021

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0178 SS= D	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 Administrator of the facility failed to ensure the exterior of the facility was free of refuse. Findings include: On 10/27/21 at 10:10 AM, the exterior ground area to the left of the kitchen's back door contained used paper cups, a full grocery store plastic bag tied with a knot, pieces of broken plastic, and several empty plastic bags. On 10/27/21 at 10:17 AM, the Dining Room Manager confirmed the area outside of the kitchen's back door contained trash and had not been cleaned up. The Dining Room Manager verbalized not knowing who had been responsible to keep the area clean. On 10/27/21 at 10:36 AM, the Business Office Manager verbalized the Administrator would not be in the facility during the survey and the Business Office Manager was acting as the facility's Administrator while the Administrator was out of the facility. On 10/27/21 at 10:46 AM, the Business Office Manager verbalized it should have been either kitchen or maintenance staff responsible to keep the area outside of the kitchen's back door clean. The Business Office Manager verbalized not knowing the last time the area had been cleaned. Severity: 2 Scope: 1	0178	1) How facility will identify - Daily and Weekly Sanitation Audits- see exhibit 1C attached 2) What measures will be put into place - In-service completed to employee's 12/01/2021 - 12/04/21 3) How facility will monitor - Daily monitoring by management 4) Responsible party for monitoring compliance - Food and Beverage Director / Designee 5) Anticipated date of correction - 10/28/2021	10/28/2021

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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 10/27/21, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. The low temperature dishwashing machine was not sanitizing during inspection. There was no detectable chlorine sanitizer during the final rinse sequence. b. Multiple dining room staff were observed entering the kitchen operations without washing their hands during inspection. c. The kitchen Quat sanitizer was replaced with a "Sink and Surface" sanitizer by the Ecolab vendor without proper training of staff. The replacement sanitizer was not accurately labeled in the janitor's closet area. Further observations included staff not using the correct test strips to monitor the new Sink and Surface sanitizer's concentration and chemical spray bottles labeled with the previous Quat sanitizer identification. Severity: 2 Scope: 3	0255	1- low temp dishwasher 1) How facility will identify - Equipment repair will be monitored every shift 2) What measures will be put into place - test strips have been replaced and log are in place 3) How facility will monitor - Food and Beverage Director / Designee 4) Responsible party for monitoring compliance - Food and Beverage Director / Designee 5) Anticipated date of correction - 10/27/2021 see exhibit 1D B - 1) How facility will identify - Entering Kitchen / Hand Washing - Training 2) What measures will be put into place - In-Service training 12/01/2021 - 12/04/2021 3) How facility will monitor - Training and observing 5 employees monthly using competency form for record. 4) Responsible party for monitoring compliance - Food and Beverage Director / Designee 5) Anticipated date of correction - 12/04/2021 C - 1) How facility will identify - making sure all labels are correct and in compliance with MSD 2) What measures will be put into place - Eco Lab changed labels 10/27/2021 3) How facility will monitor - facilities maintenance director will review all chemicals for correct labels in accordance with MSD 4) Responsible party for monitoring compliance - Food and Beverage Director / Designee 5) Anticipated date of correction - 10/27/2021	12/04/2021
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	0593	1) How facility will identify - All Visitors and Employee's are screened at front desk by designated receptionist - following Infection Prevention and Control Plan for Residential	10/28/2021

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	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, document review, and interview, the Administrator failed to ensure a safe environment for 32 of 32 residents by not screening visitors to the facility for temperature and signs and symptoms of COVID-19 (COVID). Findings include: Health Screening On 10/27/21 at 8:30 AM, upon entry to the facility, the five State Surveyors were not screened for temperature and signs and symptoms of COVID. On 10/27/21 at 3:05 PM, the Business Office Manager (BOM) confirmed the five State Surveyors were not screened for temperature and signs and symptoms of COVID-19 upon entrance to the facility. The BOM verbalized the facility's current practice was to not screen visitors, only staff. The BOM verbalized the BOM did not know the current Centers for Diease Control (CDC) guidelines and was following the facility's policy. The facility's policy titled, "COVID Navigational Guidelines" effective 10/04/21, documented the current Community Status was designated Partially Open with one resident testing positive for COVID, with current placement in the hospital. In the post vaccination phase of COVID-19 pandemic, the Partially Open Community Status documented visitors, essential and non-essential, were to wear masks and screening at the front desk was not required. The Infection Prevention and Control Plan for Residential Facilities Coronavirus Disease 2019 (COVID-19) Response Best Practices dated September 20, 2021, and distributed by the State of Nevada Bureau of Health Care Quality and Complaince to all Residential Facilities for Groups on 10/12/21, documented designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the		Facilities. 2) What measures will be put into place - Signs on all secured entry doors directing all visitors to front entry only for screening 3) How facility will monitor - All doors are secured with the exception of main entry - receptionist takes temperature and has visitor answer all screening questions in log as well for our records. See exhibit C1 attached 4) Responsible party for monitoring compliance - Executive Director / Designee 5) Anticipated date of correction - 10/28/2021	

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	presence of fever and symptoms of COVID-19 before starting each shift/when they enter the building. Severity: 2 Scope: 3			
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to obtain a physician's order for Oxygen and post	0690	1) How facility will identify - making sure all in house transfers to assisted living have the same check list as any new resident move-in so this does not get missed. 2) What measures will be put into place - Director of Resident Care will make sure residents moving into community who use oxygen will have an physicians order and have No Smoking Oxygen in use place card on residents door. 3) How facility will monitor - physicians orders / Mar / medication audits 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 10/27/20121	10/27/2021

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	signage indicating Oxygen was in use for 1 of 5 residents using Oxygen during the environmental tour (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 09/29/10, with diagnoses including chronic obstructive pulmonary disorder. On 10/27/21 at 10:43 AM, Resident #11 was wearing a nasal cannula connected to an Oxygen concentrator. The flow rate of Oxygen was set at 3 liters per minute (LPM). Resident #11 verbalized Resident #11 received Oxygen at 2.5 LPM. Resident #11's clinical record lacked documented evidence of a physician's order for Oxygen. Resident #11's door lacked signage indicating Oxygen was in use. The doors of the facility lacked signage indicating Oxygen was in use in the facility. On 10/27/21 at 11:49 AM, the Director of Resident Care confirmed Resident #11's clinical record lacked documented evidence of a physician's order for Oxygen. The Director of Resident Care explained Oxygen is considered a medication and admitted Resident #11 was receiving Oxygen without a physician's order. The Director of Resident Care confirmed the door to Resident #11's apartment lacked signage indicating Oxygen was in use. The Director of Resident Care explained it was important for signage indicating Oxygen was in use because Oxygen was flammable. Facility policy titled "Oxygen Utilization and Storage", revised 11/14/05, documented residents who utilize Oxygen would have written orders from the physician that specify type of oxygen, liter flow, method of administration, and time/parameters and "Oxygen-No Smoking" signs would be posted outside the door of the resident's apartment. Severity: 2 Scope: 1			

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		A. BUILDING _____ B. WING _____	**10/27/2021**

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0859 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) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 10 sampled residents received an annual physical examination (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 01/23/20 with diagnoses including displaced pilon fracture of the right tibia and right fibula. The resident's file contained an initial physical examination dated 01/22/20, however, lacked documented evidence of an annual physical examination for 2021. On 10/27/21 at 2:35 PM, the Director of Resident Care acknowledged the missing annual physical and was unable to provide an annual physical examination for 2021 for Resident #7. Severity: 2 Scope: 1	0859	1) How facility will identify - using a spreadsheet to track annual physical exams of residents to comply with State Regulations. 2) What measures will be put into place - using spreadsheet and audits 3) How facility will monitor - audits 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 11/10/2021	11/10/2021
0876 SS= E	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 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	0876	1) How facility will identify - All residents living in assisted living and requiring medication management will have a signed Ultimate User Agreement 2) What measures will be put into place - Ultimate User Agreement - see attached document 3) How facility will monitor - monthly resident file audits 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 12/08/21	12/08/2021

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	NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to ensure an Ultimate User Agreement was signed upon resident admission for 4 of 10 sampled residents (Resident #2, #3, #10 and #5). Findings include: Resident #2 Resident #2 was admitted to the facility on 03/03/21, with diagnoses including hypertension, hypothyroidism, glaucoma, and weakness. Resident #2's record lacked documented evidence of a signed Ultimate User Agreement. On 10/27/21 at 11:23 AM, the Medication Technician/Resident Assistant confirmed Resident #2's record lacked a signed Ultimate User Agreement. On 10/27/21 at 11:23 AM, the Director of Resident Care confirmed the facility had been administering medications to Resident #2. The Director of Resident Care confirmed an Ultimate User Agreement should have been completed. Resident #3 Resident #3 was admitted to the facility on 10/31/20, with diagnoses including hypertension, arthritis, cognitive memory loss, and dementia. Resident #3's record lacked documented evidence of a signed Ultimate User Agreement. On 10/27/21 at 11:50 AM, the Medication Technician/Resident Assistant confirmed Resident #3's record lacked a signed Ultimate User Agreement. On 10/27/21 at 1:35 PM, the Director of Resident Care confirmed the facility had been administering medications to Resident #3. The Director of Resident Care confirmed an Ultimate User Agreement should have been completed. Resident #10 Resident #10 was admitted to the facility on 06/02/21, with diagnoses including hypertension, osteoarthritis, anxiety, hard of hearing, hypothyroidism, and dementia. Resident #10's record lacked documented evidence of a signed Ultimate User Agreement. On 10/27/21 at 1:43 PM, the Director of Resident Care confirmed the facility had			

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	been administering medications to Resident #10. The Director of Resident Care confirmed an Ultimate User Agreement should have been completed. Resident #5 Resident #5 was admitted to the facility on 09/01/20, with diagnoses including heart failure, atrial fibrulation, edema, and obstructive sleep apnea. Resident #5's record lacked documented evidence of a signed Ultimate User Agreement. On 10/27/21 at 1:50 PM, the Director of Resident Care confirmed the facility had been administering medications to Resident #5. The Director of Resident Care confirmed an Ultimate User Agreement should have been completed. The Director of Resident Care explained an Ultimate User Agreement allowed the facility to store and administer medications to residents. Facility policy titled "Medication Management," effective 04/01/19, documented medication supervision/assistance and/or medication administration was performed in accordance with state laws and regulations. Severity: 2 Scope: 2			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the physician. If a physician orders a change in	0878	1) How facility will identify - weekly med cart audits - see attached document 2) What measures will be put into place - In-Service with care staff / weekly med cart audits - see attached document 3) How facility will monitor - Director of Resident Care will monitor assigned med cart audits 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 12/18/2021	12/18/2021

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	the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (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 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, the 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 observation, interview and record review, the facility failed to ensure a medication was available onsite for 1 of 10 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/31/20, with diagnoses including hypertension, arthritis, cognitive memory loss, and dementia. A physician's order dated 04/15/21, documented senexon-s 8.6-50 milligram (mg) tablet, take one tablet by mouth twice daily, if needed for constipation. Resident #3's Medication Administration Record (MAR) dated October 2021, documented senexon-s 8.6-50 mg tablet, take one tablet by mouth twice daily, if needed for constipation. On 10/27/21 at 12:54 PM, the Medication Technician/Resident Assistant confirmed the senexon-s 8.6-50 mg medication was not on the medication cart and the medication had not been discontinued by the physician. The Medication Technician/Resident Assistant confirmed			

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	the medication should have been on the cart in the event the resident needed the medication. Severity: 2 Scope: 1			
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. 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, interview, and clinical record review, the facility failed to ensure self-administered medications were secure for one resident during the environmental tour (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 09/29/10, with diagnoses including chronic obstructive pulmonary disorder. On 10/27/21 at 10:42 AM, unsecured medications were in Resident #11's bathroom cabinet. One bottle of Acetaminophen, 500 milligram tablets, a bottle of Aleve, and a bottle of eye drops. On 10/27/21 at 10:43 AM, Resident #11 verbalized medications were stored in the bathroom cabinet and were not secured in a locked box. The resident admitted the apartment door was not locked when the	0920	1) How facility will identify - daily checks when care staff enter apt. 2) What measures will be put into place - In-Service Training - 12/18/2021 3) How facility will monitor - In-Service to care staff - 12/18/2021 - Med Techs will do a weekly sweep on all residents that are self-administering medications and notifying Director of Resident Care. 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 10/28/2021	10/28/2021

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	resident left the apartment. On 10/27/21 at 10:44 AM, Resident #11's daughter verbalized they prefer Resident #11 not to lock the apartment door so staff could get into the apartment quickly. The resident's daughter confirmed Resident #11 does not secure medications in a locked box or lock the apartment door when the resident was out of the apartment. On 10/27/21 at 10:46 AM, the Director of Resident Care confirmed Resident #11's medications were not secured in a locked box. The Director of Resident Care admitted medications should be secured in a locked box or the apartment door should be locked when the resident was not in the apartment for resident safety. Facility policy titled "Medication Management," effective 04/01/19, documented residents who engaged in Self-Administration of medications may store medications in a secure area in their apartment. Severity: 2 Scope: 1			

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #3 and #9). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/31/20, with diagnoses including hypertension, arthritis, cognitive memory loss, and dementia. Resident #3's record contained a comparison X-ray of the chest to rule out acute disease dated 10/01/20. Resident #3's record lacked documented evidence of a positive TB test result. On 10/27/21 at 1:35 PM, the Director of Resident Care confirmed Resident #3's record lacked a positive TB test. The Director of Resident Care confirmed a TB documenting a positive TB result should have been in the resident's record to ensure the facility was screening the resident appropriately. Severity: 2 Scope: 1	0936	1) How facility will identify - Director of Resident Care will monitor with use of TB Tracker spread sheet - see attached document - until DRC has all TB's inputted into PCC for documentation and reporting. 2) What measures will be put into place - Director of Resident Care will be sure to input TB immunizations in to PCC so he will be able to run report for any upcoming due TB's - until that part is completed DRC will use the TB tracker form. 3) How facility will monitor - Director of Resident Care will monitor through monthly reviews of Tracker Sheet and run report in Point Click Care to check due dates 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 12/23/2021	12/23/2021
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential	0938	1) How facility will identify - All assisted living residents are in Point Click Care and assessments are documented and tasks pop up when next assessment is due. 2) What measures will be put into place - DRC will ensure all assessment dates are	12/06/2021

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	facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to ensure an annual Activities of Daily Living (ADL's) assessment was completed timely for 2 of 10 sampled residents (Resident #4 and #9). Findings include: Resident #4 Resident #4 was admitted to the facility on 09/18/19 with diagnoses including hypertension, hypothyroidism, and aortic stenosis. Resident #4's file documented an annual ADL assessment on 04/22/20. The residents file documented an annual ADL assessment completed on 09/27/21, approximately five months late. Resident #9 Resident #9 was admitted to the facility on 07/02/20 with diagnoses including hypertension, thyroid nodule, and anxiety disorder. Resident #9's file documented an initial ADL assessment on 07/02/20. The resident's file documented an annual ADL assessment completed on 09/21/21, approximately two months late. On 10/27/21 at 2:40 PM, the Director of Resident Care acknowledged the late ADL assessments for Resident #4 and Resident #9. The facility's policy revised 11/14/05 titled, "Resident Assessment and Re-Assessment		accurate in PCC so tasks due scheduled will be accurate 3) How facility will monitor - PCC system will bring up all tasks that are due and past due 4) Responsible party for monitoring compliance - Director of Resident Care / Designee 5) Anticipated date of correction - 12/31/21	

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	Process," documented re-appraisals/re-assessments 1. A re-appraisal/re-assessment shall be performed for each resident, at a minimum every six (6) months, or as indicated by a resident change in condition. Severity: 2 Scope: 2			