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 _____	**10/20/2022**

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

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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 10/20/22. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was 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 34. Ten resident files were reviewed and ten employee files were reviewed. The facility received a grade of C. There were two complaints investigated. Complaint #NV00065883 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: Medication bottle had incorrect physician order instructions for a scheduled medication. Allegation #2: Medication Administration Record did not match medication physician orders. Allegation #3: Resident rooms were dirty. Allegation #4: Resident's clothes were soiled. Allegation #5: There was moldy food in the kitchen refrigerator. Allegation #6: Trash was overflowing in resident rooms. Allegation #7: Strong odors indicative of urine were throughout the facility. Allegation #8: Physician orders for medications were discontinued by Medication Technicians, not the physician for the resident. Allegation #9: Medications were held in the facility without a physician order. Allegation #10: Resident Oxygen concentrators were inoperable. Allegation #11 Unauthorized medications in resident rooms. The investigation into the allegations included the following: Observation of resident rooms, cleanliness of resident rooms, residents well groomed, odors in the facility, food items held in the kitchen, medication administration, medications held in resident rooms and Oxygen concentrators operating	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: PATRICK WARD Title: Executive Director Date: 12/28/2022

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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	appropriately. Interviews were conducted with the Administrator, the Maintenance Supervisor, a Caregiver, the Business Office Manager, a Medication Technician, the Corporate Nurse, the Food Services Supervisor, two Housekeepers and eight residents. Document review included Medication Administration Records, resident physician orders, housekeeping schedules, incident reports, grievance procedures, caregiver and medication technician trainings, and maintenance logs. Policy review included Housekeeping and Laundry Department Training and Operations Manual, Apartment Cleaning Procedures, Resident Care Guidelines, Abuse, Neglect and Exploitation Prohibition and Prevention Program, Complaints and Grievances, Medication Management and Medication Storage. Complaint #NV00066208 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: A Caregiver was showering a resident with cold water and spraying water in the resident's face. Allegation #2: A Medication Technician would not administer medications to a resident unless the resident begged for the medications. Allegation #3: Incorrect medications being administered to residents. The investigation into the allegations included: Observation of care being provided to residents, resident and staff interactions, body language of residents while interacting with staff, medication administration and assistance provided to residents. Interviews were conducted with the Administrator, a Caregiver, a Medication Technician, the Corporate Nurse, and eight residents. Document review included Medication Administration Records, physician orders, Activities of Daily Living, physician assessments, incident reports, and caregiver and medication technician trainings. Policy review included Resident Care Guidelines, Abuse, Neglect and Exploitation Prohibition and Prevention Program, Complaints and Grievances and			

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	Medication 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:			
0065 SS= F	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 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 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) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Inspector Comments: Based on document review and interview, the facility failed to ensure 4 of 4 sampled employees hired with over a year of employment received eight hours of annual training to care for elderly and disabled residents (Employee #1, #9, #11, and #12). Findings include: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 03/05/18. Employee #1's personnel file lacked documented caregiver training. Employee #9 Employee #9 was hired by the facility as Resident Assistant with a start date of 02/24/20. Employee #9's personnel file documented 3.8 hours of caregiver training. Employee #9's personnel file lacked documented evidence of an additional 4.2	0065	Tag 0065 1) How Facility will identify others - The facility now keeps a master tickler file of annual training and follows an annual training schedule/matrix to identify and prevent others from being affected. 2) What Measures or systematic changes will be put into place - Resident need topic trainings are offered to all care staff monthly and annually and all care staff and executive Director are up to date for company requirements. 3) How Facility will monitor -This is monitored monthly by Human Resource Director and or designee. 4) Responsible Party - Human Resource Director and or designee. 5) Anticipated date of correction - 12/20/22 6) See Attached tracking tool	12/20/2022

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	hours of annual caregiver training to care for elderly and disabled residents. Employee #11 Employee #11 was hired by the facility as Resident Assistant with a start date of 08/04/21. Employee #'11s personnel file documented 6.15 hours of caregiver training. Employee #11's personnel file lacked documented evidence of an additional 1.85 hours of annual caregiver training to care for elderly and disabled residents. Employee #12 Employee #12 was hired by the facility as Resident Assistant with a start date of 11/26/20. Employee #12's personnel file documented 3.8 hours of caregiver training. Employee #12's personnel file lacked documented evidence of an additional 4.2 hours of annual caregiver training to care for elderly and disabled residents. On 10/22/22 at 2:00 PM, the Human Resources Director confirmed the findings and verbalized the employees' personnel file lacked the documentation for a total of eight hours of annual caregiver training for elderly and disabled residents as required. Severity: 2 Scope: 3			

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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 interview and clinical record review, the facility failed to ensure a physical examination including a review of systems was completed annually for 1 of 10 sampled residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 09/06/13, with diagnosis including chronic obstructive pulmonary disease. Resident #4's clinical record contained a physical examination with a review of systems dated 06/17/21. The resident's clinical record lacked documented evidence of an annual physical examination with a review of systems completed by June 2022. On 10/20/22 at 11:59 AM, the Clinical Specialist confirmed Resident #4 did not have an annual physical evaluation including a review of systems on file for the annual due for 2022. Severity: 2 Scope: 1	0859	Tag 0859 1) How Facility will identify others - The facility now keeps a master tickler file of annual physical examinations to identify and prevent others from being affected. 2) What Measures or systematic changes will be put into place - following the master tickler file. 3) How Facility will monitor - Master Tickler file will be monitored monthly by Director of Resident Care and or designee 4) Responsible Party - Director of Resident Care and or designee 5) Anticipated date of correction - 10/31/22 6) See Attached tracking tool	10/31/2022

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0876 SS= D	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 NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an ultimate user agreement was completed for 1 of 10 sampled residents (Residents #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 03/31/21, with a diagnoses including generalized weakness, anxiety and hypothyroidism. Resident #3's clinical record contained an Ultimate User Agreement dated 10/12/22, over one year after the resident's admission. On 10/20/22 at 11:54 AM, the Clinical Specialist confirmed Resident #3's Ultimate User Agreement was dated and signed over 1 year after the resident's admission. The Clinical Specialist confirmed the facility began administering medications to Resident #3 on the day of admission. Severity: 2 Scope: 1	0876	Tag 0876 1) How Facility will identify others - All user agreements present and signed and maintained in their medical record by date. A move-in checklist is utilized by community with oversight by the executive Director. 2) What Measures or systematic changes will be put into place - This checklist and audit will identify and prevent others from being effected. 3) How Facility will monitor -This is overseen by Executive Director and or designee 4) Responsible Party - Executive Director and or designee 5) Anticipated date of correction - 6) See Attached tracking tool	10/31/2022
0933 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	0933	Tag 0933 1) How Facility will identify others - All residents have an accurate and completed standard physicians assessment placement determination in their medical chart. A move-in checklist is utilized by community with oversight by Executive Director and or designee.	10/31/2022

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	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: (d) A statement from the resident ' s physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. Inspector Comments: Based on record review and interview, the facility failed to obtain and ensure accuracy of a Standard Physician Assessment and Placement Determination for 3 of 5 residents (Resident #3, #5 and #2). Findings include: Resident #3 Resident #3 was admitted to the facility on 03/31/21, with a diagnosis of generalized weakness. Resident #3's record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #5 Resident #5 was admitted to the facility on 04/07/22, with diagnosis including heart failure. Resident #5's record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #2 Resident #2 was admitted to the facility on 07/25/22, with diagnosis including other injury of right kidney. Resident #2's clinical record contained a Physician Placement Determination Statement indicated the resident was not in an appropriate facility type. On 10/20/22 at 12:06 PM, the Clinical Specialist confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #3 and #5, and was inaccurate for Resident #2. Severity: 2 Scope: 1		2) What Measures or systematic changes will be put into place - This checklist and audit will identify and prevent others from being affected. 3) How Facility will monitor -This is overseen by the Executive Director and or designee 4) Responsible Party - Executive Director and or designee 5) Anticipated date of correction - 10/31/22 6) See Attached tracking tool	
0936 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents	0936	Tag 0936	10/31/2022

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	of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #4, #6, #8, and #9). Findings include: Resident #6 Resident #6 was admitted to the facility on 10/22/21 with diagnoses including dysphagia, chronic obstructive pulmonary disease, and dementia. Resident #6's clinical record documented evidence of a one-step TB test administered on 10/14/22 and read negative on 10/17/22. The resident's record lacked documented evidence of a two-step TB test upon admission. On 10/20/22 at 11:34 AM, the Clinical Specialist confirmed Resident #6's two-step TB test documentation was not on site and was unable to provide the documented evidence of a two-step TB test upon admission. Resident #8 Resident #8 was admitted to the facility on 05/12/21 with diagnoses including cachexia and severe protein calorie. Resident #8's clinical record documented evidence of a one-step TB test administered on 10/14/22 and read negative on 10/17/22. The resident's record lacked documented evidence of a two-step TB upon admission. On 10/20/22 at 11:39 AM, the Clinical Specialist confirmed Resident #8's two-step TB test documentation was		1) How Facility will identify others - All residents subsequently received a late tuberculosis skin test by 10/31/22. The facility now keeps a master tickler file of annual tuberculosis records to identify and prevent others from being affected. 2) What Measures or systematic changes will be put into place - Master Tickler File 3) How Facility will monitor - In addition copies of the annual tuberculosis administration form can be found in their medical record and are up to date 4) Responsible Party - This will be monitored monthly by Director of Resident Care and or designee 5) Anticipated date of correction - 10/31/22 6) See Attached tracking tool	

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	not on site and was unable to provide the documented evidence of a two-step TB test upon admission. Resident #9 Resident #9 was admitted to the facility on 11/17/18 with diagnoses including chronic obstructive pulmonary disease, and chronic kidney disease. Resident #9's clinical record documented evidence of a one-step TB test administered on 07/13/21 and read negative on 07/15/21. Resident #9's clinical record lacked documentation of a TB test administered in 2022. On 10/20/22 at 11:40 AM, the Clinical Specialist confirmed Resident #9's TB test verbalized the TB test needed to be completed by the beginning of July 2022. Resident #4 Resident #4 was admitted on 09/06/13 with diagnosis including chronic obstructive pulonary disease. Resident #4's file contained a two-step TB test was completed in 2021, with the first step read as negative on 06/26/21 and the second step read as negative on 07/14/21. The resident's filed contained an annuual one-step TB test read as negative on 10/17/22. The 2022 annual TB test was three months late and should have been completed by 07/31/22. On 10/20/22 at11:59 AM, the Clinical Specialist confirmed Resident #4's TB test for 2022 was three months late and verbalized the TB test needed to be completed by the end of July 2022. Severity: 2 Scope: 2			
1001 SS= E	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 6 employees received four hours of initial training to care for elderly and disabled residents, within 60 days of	1001	Tag 1001 1) How Facility will identify others - All care staff during initial training will receive required training and orientation including on the job training with a designated care staff monitored by Director of Resident Care and or designee and complete an orientation competency and checklist. 2) What Measures or systematic changes will be put into place - A copy of a completed competency and checklist can be found in each care staffs personnel file. 3) How Facility will monitor - This is monitored monthly for all new hires by Human Resource Director and or designee	12/20/2022

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	hire (Employee #6, #7, #8, and #13). Findings include: Employee #6 Employee #6 was hired on 06/09/22 as a Resident Assistant. Employee #6's personnel file documented three and ¾ hours of annual caregiver training. Employee #6's personnel file lacked documented evidence of an additional ¼ hours of annual caregiver training to care for elderly and disabled residents completed within 60 days of hire. Employee #7 Employee #7 was hired on 09/01/22 as a Resident Assistant. Employee #7's personnel file documented two and ¼ hours of annual caregiver training. Employee #7's personnel file lacked documented evidence of an additional one and ¾ hours of annual caregiver training to care for elderly and disabled residents completed within 60 days of hire. Employee #8 Employee #8 was hired on 05/05/22 as a Resident Assistant Employee #8's file lacked documented evidence of the initial four hours of caregiver training within 60 days of hire. Employee #13 Employee #13 was hired on 7/26/22 as a Resident Assistant. Employee #13's file lacked documented evidence of the initial four hours of caregiver training within 60 days of hire. On 10/22/22 at 2:51 PM, the Human Resources Director confirmed the findings and verbalized the employees' personnel file lacked the documentation for four hours of initial Caregiver training within 60 days of hire. Severity: 2 Scope: 3		4) Responsible Party - Human Resource Director and or designee 5) Anticipated date of correction - 12/20/22 6) See Attached tracking tool	
1540 SS= F	Cultural Competency Training Inspector Comments: Based on record review and interview, the facility failed to ensure employees received cultural competency training within 30 days of their date of hire for 10 of 10 employees who worked for the facility greater than 30 days (Employee #1, #5, #6, #7, #8, #9, #10, #11, #12, and #13). Findings include: On 10/20/22, a review of employee files revealed the following: Employee #1 Employee #1 was hired on 03/05/18 as	1540	Tag 1540 1) How Facility will identify others - We have added Cultural Competency to our new hire training checklist and annual training 2) What Measures or systematic changes will be put into place - Team members will complete the Cultural Competency training course no later than 3/30/23. We have 88 employee's to complete this training and I am working with High Sierra AHEC to teach Cultural Competency class. They are doing only two classes a month and we are	03/30/2023

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	Executive Director. Employee #1's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #5 Employee #5 was hired on 02/24/22 as Resident Assistant. Employee #5's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #6 Employee #6 was hired on 06/09/22 as Resident Assistant. Employee #6's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #7 Employee #7 was hired on 09/01/22 as Resident Assistant. Employee #7's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #8 Employee #8 was hired on 05/05/22 as Resident Assistant. Employee #8's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #9 Employee #9 was hired on 02/24/20 as Resident Assistant. Employee #9's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #10 Employee #10 was hired on 07/07/22 as Resident Assistant. Employee #10's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #11 Employee #11 was hired on 08/04/21 as Resident Assistant. Employee #11's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #12 Employee #12 was hired on 11/26/20 as Resident Assistant. Employee #12's personnel record lacked documented evidence of completion of an approved cultural competency training course. Employee #13 Employee #13 was hired on 07/26/22 as Resident Assistant. Employee #13's personnel record lacked documented evidence of completion of an approved		setting them up as a vendor for payment for these classes. With this many employee's they can not have over 22 persons per class so we will need 2-3 months to get everyone through the 9 hour class. *Nevada Cultural Competency Staff* nvculturalcompetency.com info@nvculturalcomptency.com Powered by High Sierra AHEC and the NVPCA 3) How Facility will monitor - this will be monitored using the new hire training checklist and annual training tickler file. 4) Responsible Party - Human Resource Director and or Executive Director 5) Anticipated date of correction - 3/30/23 6) See Attached tracking tool	

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 _____	**10/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	cultural competency training course. On 10/20/22 at 2:56 PM, the Human Resources Director verbalized the facility just found out this training was required and the facility was waiting for a trainer. Severity: 2 Scope: 3			