STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	116	A. BUILDING _____ B. WING _____	08/07/2023

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 conducted at your facility on 08/07/23. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 45 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 37. 10 resident files were reviewed and 15 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. 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		
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse	0074	1)How you will correct the specific finding(s) stated in the Statement of Deficiencies; Monthly required training e-mails to department managers to notify their employee's will continue and using a	08/07/2023

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	of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and		Tickler file for all trainings will help keep track when completed. If not completed as scheduled then we implement the Notice of Deficiency Temporary suspension until completion. See attached documents **Please note that Employee #1 had competed annual Elder Abuse before due date and during audit was not logged correctly on attestation sheet. Certificates of completion added to documents. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; We have implemented a Tickler file to track and a Temporary suspension notice to employee until completed. Notice of Deficiency letter sent to our legal department and is expected to be approved and in use by November 1,2023. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; BOM/ HR Director will monitor more closely to ensure employees are being removed from the schedule temporarily until their required training is completed. Signed letter by employee and Executive Director will be placed in employee's file showing removal from schedule until completed. 4) The title of the person (position) responsible for ensuring the plan of	

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	violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 5 of 12 employees received initial elder abuse training prior to beginning work at the facility and annually, thereafter (Employee #1, #4, #6, #7, and #12). Findings include: On 08/07/23, the		correction is implemented; BOM/HR Director and or Executive Director 5) The date the corrective action will be completed; Corrective action was completed 8/07/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Tickler files are now in use for all required training for new hires and annual employee training. See attached documents samples	

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	Accountant was provided the Personnel Check List to complete for 12 sampled employees. On 08/07/23, the Accountant provided the completed form with the following information: Findings include: On 08/07/23, the Accountant was provided the Personnel Check List to complete for 12 sampled employees. On 08/07/23, the Accountant provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 03/04/18. On 08/07/23, Employee #1's personnel file contained an elder abuse training dated 01/24/22 and an elder abuse training dated 04/05/23, more than two months late. Employee #4 Employee #4 was hired by the facility as Resident Assistant with a start date of 04/25/23. On 08/07/23, Employee #4's personnel file contained an elder abuse training dated 08/03/23, more than three months late. Employee #6 Employee #6 was hired by the facility as Resident Assistant with a start date of 05/18/23. On 08/07/23, Employee #6's personnel file contained an elder abuse training dated 05/23/23, five days late. Employee #7 Employee #7 was hired by the facility as Housekeeper with a start date of 06/27/11. On 08/07/23, Employee #7's personnel file contained an elder abuse training dated 02/03/22, and an elder abuse training dated 04/04/23, two months late. Employee #12 Employee #12 was hired by the facility as Maintenance with a start date of 08/29/12. On 08/07/23, Employee #12's personnel file contained an elder abuse training dated 02/23/22, and an elder abuse training dated 04/04/23, more than a month late. On 08/07/23 in the afternoon, the Accountant provided the Attestation of Compliance form, signed and dated 08/07/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation Severity: 2 Scope: 2			
0255	Permits-Comply with NAC 446 on Food	0255		10/20/202

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SS= E	Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 8/7/23, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. Two refrigeration units were not holding a temperature of 41 degrees F. or below. The server station three-door refrigerator and a reach-in single door kitchen refrigerator were at 50 degrees F. during inspection. Poor refrigeration temperature recovery during service was also observed with these units. 2. Major Violations: a. Multiple non-food contact surfaces were dirty. The cook's line equipment including the surrounding wall and attached equipment were heavily soiled with grease. Multiple floor sinks throughout the kitchen and server station were not clean. Multiple areas under mounted equipment, shelving, countertops and other supportive food equipment were dirty. b. The paper towel dispenser in the Assisted Living serving kitchen was in disrepair. This was a repeat citation from previous inspections. 3. Equipment and Maintenance Violations: a. The temperature display for multiple refrigeration units were not accurate. Units with internal thermometers were also no reading the correct temperature. In addition, a single door reach-in refrigerator was showing and error code on its temperature display. Interview with the dietary manager revealed the facility refrigerators have not had a routine service in the recent months. Severity: 2 Scope: 2		1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; **Critical Violation - All refrigeration in Dietary have been serviced by Refrigeration Company on August 15, 2023 and are holding temperatures. See attached document for servicing. *Major Violation - Non-food contact surfaces Dirty - over the week of 9/18 we have been tackling one area at a time. Cleaning and sanitizing surfaces as well as cleaning each floor sink. A weekly cleaning schedule has been put into place to be signed off on each week by Food and Beverage Director. *Paper towel dispenser - fixed 8/07/23 and will be monitored by Food and Beverage Director. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; **New Thermometers have replaced all older thermometers in every refrigeration unit. Temp Logs are in place and in-service completed with food service staff. We have also set up a Bi-annual maintenance plan with our refrigeration company. * Cleaning schedule and Sanitation / cleanliness daily checklist 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; **Use of Temp logs.	3

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			* Cleaning schedule and Sanitation / Cleanliness daily checklist 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; **Food and Beverage Director and or Designee * Food and Beverage Director and or Designee 5) The date the corrective action will be completed; **8/15/23 *8/20/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; ** By auditing temp logs and routine maintenance checks of all refrigeration units. - see attached document. * We are seeking outside source for added monthly deep cleaning to all service areas of kitchen. We will also be reviewing cleaning schedule and check lists weekly. See attached documents.	
0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in	0450	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; ** Please note - This should not have been a deficiency - the BOM did not	08/07/2023

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	first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 1 of 6 employees had the required cardiopulmonary resuscitation (CPR) and first aid training within 30 days of hire (Employee #2). Findings include: On 08/07/23, the Accountant was provided the Personnel Check List to complete for 12 sampled employees. On 08/07/23, the Accountant provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Director of Resident Care with a start date of 02/09/23. On 08/07/23, Employee #2's personnel file contained CPR and first aid training dated 03/15/20 with an expiration date of 03/15/22. The facility lacked documented evidence the training had been renewed. On 08/07/23 in the afternoon, the Accountant provided the Attestation of Compliance form, signed and dated 08/07/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1		write down employee#2 dates correctly on the attestation sheet. This employee was clearly in compliance as you can see in attached documents. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; We are using a Tickler file to keep track of training and certifications renewal dates. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; The Tickler files will be reviewed and monitored by The BOMand or designee 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; BOM and or designee 5) The date the corrective action will be completed; 8/07/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; By using the Tickler file system that BOM has set up -see attached document	

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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 and interview, the facility failed to ensure an oxygen tank was secured. Findings include: On 08/07/23 at 10:43 AM, Room 175 contained a small oxygen cylinder laying on it,s side on the floor. On 08/07/23 at 10:43 AM, the Director of Resident Care confirmed the oxygen tank was unsecured	0690	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; Oxygen tank immediately secured in an upright position then picked up by DME due to non use by resident. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; *The Director of Resident Care (DRC) to establish a working relationship with DME company and to outline the facility's policies and expectations for safe delivery and storage on oxygen equipment, including oxygen tanks. The DRC and prescribing physicians will determine if the residents are eligible for a stationary or mobile oxygen concentrator in place of oxygen tanks, if the resident requires long term or lifelong use of oxygen. *Random resident room rounds for care staff to perform safety checks of the residents apartments wherein they will identify unsecured oxygen tanks. Each resident chart and individual service plan will notate the assigned DME company. If it is identified that an oxygen tank is being improperly stored, the care staff will: 1) immediately correct the safety hazard by ensuring that oxygen tanks are secured in an upright position inside a rolling oxygen caddy or oxygen rack. 2) make contact with the corresponding DME company to request immediate correction to their delivery methods; and 3) notify the DRC that the	10/08/2023

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	and verbalized oxygen tanks should be kept secured. The facility policy titled "Oxygen Utilization and Storage," revised 09/01/19, documented, "6. Used or unused oxygen containers are properly anchored to the bed, floor, wall, or carrier to prevent the container from falling over." Severity: 2 Scope: 1		safety hazard has been identified and addressed. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; The DRC will perform random apartment inspections to ensure the DME's and community care staff are following proper protocol. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Director of Resident Care (DRC) and or designee 5) The date the corrective action will be completed; The specific finding was corrected on 8/08/23. The systematic changes have been initiated and will be on going. DRC provided an announcement to the staff and one on one conversations with all Care staff regarding this topic. I will reinforce the education at our scheduled in-service 10/19/23. 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; All residents with oxygen assessed to ensure compliance.	
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of	0870	1) How you will correct the specific finding(s) stated in the Statement of	10/06/2023

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	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 clinical record review, the facility failed to ensure a resident had a review of medications for accuracy and appropriateness completed at least once every six months for 1 of 10 sampled residents (Resident #8) and pharmacy medication review recommendations were addressed and documented for 2 of 10 sampled residents (Resident #1 and #5). Findings include: Resident #8 Resident #8 was admitted to the facility on 03/09/22, with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris. Resident #8's clinical record included a medication review completed on 07/11/22 and 04/12/23. The second review was due to be completed no later than 01/11/23, and subsequently every six months. Resident #1 Resident #1 was admitted to the facility on 05/13/15, with diagnoses including essential primary hypertension, mild cognitive impairment, and malignant neoplasm of colon, unspecified. A physician's order dated 11/07/22, documented Systane 0.4 - 0.3 percent (%) solution, administer one to two drops into both eyes two times per day. A		Deficiencies; Review of most recent Pharmacy Review report, recommendations sent to physician for review and updated orders. See attached document 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; All Future pharmacy reviews will be reviewed, signed and addressed upon completion. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Proper record keeping will ensure easy access for future State Surveys. All future pharmacy reviews will be reviewed, signed and addressed upon completion. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Director of Resident Care and or designee 5) The date the corrective action will be completed; Going forward all corrections from Pharmacy review will occur within a week of review findings. As for this correction we will have completed by 10/06/23. 6) How you will identify and correct	

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	physician's order dated 06/08/23, documented polyethylene glycol 3350 (Miralax) 17 gram (g)/scoop powder, take 17 g by mouth daily as needed for constipation. Resident #1's record review included a medication review completed on 04/12/23. The medication review included the following pharmacist recommendations: -Systane order has a range for the dosage, please remove the range per Centers for Medicare and Medicaid Services (CMS) guidelines. -Polyethylene glycol order did not state how many packets to mix with water, please add the number of packets to the order (such as mix one packet with six ounces (oz.) of water and give by mouth daily as needed for constipation, hold for loose stools). The Director of Nursing's Comments, the signature line, and date line, were left blank and unsigned. Resident #5 Resident #5 was admitted to the facility on 08/04/20, with a diagnosis of chronic obstructive pulmonary disease. A physician's order dated 05/20/22, documented acetaminophen extra strength tablet, 500 milligram (mg), administer 1000 mg, by mouth every eight hours as needed (PRN) for pain. Resident #5's Medication Administration Record documented oxycodone immediate release (IR) 10 mg tablet, administer 10 mg twice daily as needed for pain. Resident #5's physician's orders, provided by the facility, did not include an order for oxycodone IR 10 mg tablets. Resident #5's record review included a medication review completed on 04/12/23. The medication review documented Resident #5 had PRN analgesic medication orders for similar indications without instructions as to a sequence, pain intensity, or site of pain for which the options should be administered for Oxycodone 10 mg and acetaminophen 500 mg. The report included the following pharmacist recommendations: -Clarify the PRN analgesic orders by including a sequence, pain intensity, and site of pain in the directions for use as both orders stated as needed for pain. The Physician's response, the "Director of Nursing's" Comments, the signature and date lines were left blank and unsigned. Severity: 2 Scope: 1		other areas having potential to be affected by the same deficient practice; N/A	

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0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 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; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 10 sampled residents (Resident #2 and #5). Findings include: Resident #2 Resident #2 was admitted to the facility on 03/03/23, for diagnoses including dementia, risk for falling, and cognitive defects. On 08/07/23, during a medication review with the Director of Resident Services (DRS), the following medications were available in the medication cart for Resident #2: - lorazepam 0.5 milligrams (mg), take one tablet by mouth every two hours as needed. - hyoscyamine 0.125 mg, take one tablet sublingually every four hours as needed. - prochlorperazine 10 mg, take one tablet by mouth every eight hours as needed. The August 2023 MAR for Resident #2 did not include the lorazepam, hyoscyamine, or prochlorperazine. A Client Medication Report for Resident #2, dated 05/05/23, documented the following orders: - lorazepam 0.5 mg, take one tablet every two hours as needed for anxiety, agitation, restlessness. - hyoscyamine 0.125 mg, take one tablet every six hours needed for secretions. - prochlorperazine 10 mg, take one tablet by mouth every eight hours as needed for nausea and vomiting. On 08/07/23 at 1:03 PM, the Director of Resident Care (Director) verbalized the	0895	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; Orders were reviewed and confirmed then updated August 2023 MAR. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; Ongoing month to month recaps will be completed to ensure all current orders are listed on MAR and ensure compliance. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Orders will be utilized during recaps along with prior month MAR. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Director of Resident Care 5) The date the corrective action will be completed; 10/06/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice;	10/06/2023

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	pharmacy was not up to date on including current resident medication orders on the resident MARs. The Director verbalized the MAR should be accurate and include the most current medication orders. Resident #5 Resident #5 was admitted to the facility on 08/04/20, with a diagnosis of chronic obstructive pulmonary disease. A physician's order dated 05/08/23, documented Levsin (hyoscyamine) 0.125 mg tablet, administer one tablet every four hours for secretions. The August 2023 MAR for Resident #5 did not include hyoscyamine. On 08/07/23 at 1:14 PM, the DRS confirmed Resident #5's MAR did not include hyoscyamine. Severity: 2 Scope: 1		MAR audit completed on all residents to ensure all orders carried over with the new month	
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, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility in 2 of 16 resident rooms with a resident self-administering medication (Room #145 and #180). Findings include: On 08/07/23, the following resident rooms contained unsecured medications: Room #145 - at 10:25 AM, the resident was not in	0920	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; All residents who self-administer medications and care staff have been educated of the importance to lock their apartment when unoccupied or keep all medications including pill organizer secured in locked box. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; Residents on move-in will understand the importance and proper procedure for self-medicating and staff will have an in-service on self med procedure to ensure compliance. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Random room rounds for those who self administer medications to ensure compliance.	08/08/2023

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	the room and the resident's daily medications were on the counter. The resident's spouse verbalized the room was not always locked when not occupied. At 11:38 AM, the resident was in the room and verbalized the room was not always locked when not occupied. Room #180 - at 10:50 AM, the resident 's medications were out on the counter. The resident verbalized the room was not always locked when not occupied. On 08/07/23 at 10:25 AM through 10:50 AM, the Director of Resident Care confirmed medications were unsecured in Rooms #145 and #180. The facility policy titled, "Medication Management," revised 06/09/23 documented, "F. 1. Residents who engage in self-administration of medications may store medications in a secure area in their apartment." Severity: 2 Scope: 1		4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Director of Resident Care and or designee 5) The date the corrective action will be completed; This was immediately addressed with residents and care staff on 8/08/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; All self-medicating resident rooms have been assessed to ensure compliance. This is ongoing	
0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, clinical record review, interview and document review the facility failed to ensure a medication was labeled with the resident's name and the name of the provider for 2 of 10 sampled residents (Resident #1 and #7) Findings include: Resident #1 Resident #1 was admitted to the facility on 05/13/15, with diagnoses including essential primary hypertension, mild cognitive impairment, and malignant neoplasm of colon, unspecified. A	0923	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; Medication cart audits of all over the counter medications to ensure labeled appropriately for compliance and resident safety. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; Staff in-service , all over the counter medications received will immediately be labeled appropriately prior to securing in medication cart	10/06/2023

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	physician's order dated 04/14/22, documented cholecalciferol (vitamin D3) 2000 unit capsule, administer one capsule by mouth every day for vitamin D deficiency. On 08/07/23, during a medication review with the Director of Resident Services (DRS), a bottle of Vitamin D3 was found in the medication cart. The DRS explained the bottle of vitamin D3 belonged to Resident #1 and confirmed the medication/supplement was not labeled with the resident's name or the name of the prescribing provider and should have been. Resident #7 Resident #7 was admitted to the facility on 05/03/23, with diagnoses including benign prostatic hypertension, lumbar arthritis, and lymphadenopathy. A physician's order dated 06/29/23, documented cholecalciferol (vitamin D3) 1000 unit tab, administer one tablet by mouth every day for vitamin D deficiency. On 08/07/23, during a medication review with the DRS, a bottle of Vitamin D3 was found in the medication cart. The DRS explained the bottle of vitamin D3 belonged to Resident #7 and confirmed the medication/supplement was not labeled with the residents name or the name of the prescribing provider and should have been. Severity: 2 Scope: 1		3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; DRC and or designee will complete random medication cart audits to ensure compliance. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Director of Resident Care and or Designee 5) The date the corrective action will be completed; 10/06/2023 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Medication Cart audits of all over the counter medications to ensure labeled appropriately for compliance	
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	0936	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; DRC will administer TB tests to these residents and complete appropriate documentation. DRC will review resident charts and create schedule to be followed. 2) What measures or systematic change(s) will be put into place to	10/06/2023

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	the regulations adopted pursuant thereto. Inspector Comments: Based on record review, and interview, the facility failed to ensure 3 of 10 sampled residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Residents #2, #8, and #1). Findings include: Resident #2 Resident #2 was admitted to the facility on 03/03/23, with diagnoses including dementia, risk for falling, and cognitive defects. Resident #2's record documented the resident had a TB test read on 03/02/23, but did not have a completed second step. On 08/07/23 at 11:42 AM, the Director of Resident Care verbalized the second step of the TB test was placed but the results were not documented and the resident's two step TB test was not completed. Resident #8 Resident #8 was admitted to the facility on 03/09/22, with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris and occlusion and stenosis of bilateral carotid arteries. Resident #8's record lacked documentation of an annual TB test for 2023. On 08/07/23 at 2:39 PM, the Director of Resident Care confirmed the annual one step TB test for Resident #8 had not been completed for 2023. Resident #1 Resident #1 was admitted to the facility on 05/13/15, with diagnoses including essential primary hypertension, mild cognitive impairment, and malignant neoplasm of colon, unspecified. Resident #1's record documented the resident had a two step TB test completed on 11/09/20. The facility lacked documented evidence the resident had an annual TB test completed in 2021, 2022, and 2023. On 08/07/23 at 2:39 PM, the Director of Resident Care confirmed the facility lacked documented evidence a annually TB test was completed for Resident #1 in 2021, 2022, or 2023 and should have been. Severity: 2 Scope: 1		ensure the deficient practice does not recur; Upon move-in, DRC will create schedule to be followed in regards to TB testing to ensure compliance. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; DRC will administer TB tests to these residents and complete appropriate documentation. DRC will review resident charts and create schedule to be followed. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Director of Resident Care 5) The date the corrective action will be completed; 10/06/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; All current residents records reviewed to ensure compliance.	
1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 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	1540	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies;	08/27/2023

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	18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 6 of 8 sampled employees required to obtain cultural competency training (Employees #3, #4, #5, #6, #9, and #11). Findings include: On 08/07/23, the Accountant was provided the Personnel Check List to complete for 12 sampled employees. On 08/07/23, the Accountant provided the completed form with the following information: Employee #3 Employee #3 was hired by the facility as Resident Assistant with a start date of 04/27/23. On 08/07/23, Employee #3's personnel file lacked a cultural competency training certificate. Employee #4 Employee #4 was hired by the facility as Resident Assistant with a start date of 04/25/23. On 08/07/23, Employee #4's personnel file lacked a cultural competency training certificate. Employee #5 Employee #5 was hired by the facility as Resident Assistant with a start date of 03/30/23. On 08/07/23, Employee #5's personnel file lacked a cultural competency training certificate. Employee #6 Employee #6 was hired by the facility as Resident Assistant with a start date of 05/18/23. On 08/07/23, Employee #6's personnel file lacked a cultural competency training certificate. Employee #9 Employee #9 was hired by the facility as Resident Assistant with a start date of 09/01/22. On 08/07/23, Employee #9's personnel file lacked a		For all Assisted Living staff upon hire will be assigned and registered for Cultural Competency with the Nevada Cultural Competency in their first two weeks of Orientation and will have completed before working on the floor with residents. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; This is now part of our new hire process for all assisted living staff. This will be monitored with our new hire and training tickler file. See attached document 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; This is now part of our new hire process for all assisted living staff. This will be monitored with our new hire and training tickler file. See attached document 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; BOM/HR and or Director of Resident Care 5) The date the corrective action will be completed; All Care staff have completed Cultural Competency by 8/27/23 6) How you will identify and correct	

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	cultural competency training certificate. Employee #11 Employee #11 was hired by the facility as Resident Assistant with a start date of 02/24/22. On 08/07/23, Employee #9's personnel file lacked a cultural competency training certificate. On 08/07/23 in the afternoon, the Accountant provided the Attestation of Compliance form, signed and dated 08/07/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. This was a repeat deficiency from the 10/20/22 annual re-licensure survey. The facility's Plan of Correction submitted 12/28/22 documented, "Team members will complete the Cultural Competency training course no later than 3/30/23." Severity: 2 Scope: 3		other areas having potential to be affected by the same deficient practice; By making the course part of our orientation for all care staff then this is completed along with all orientation and training before employee works on the floor with residents.	
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	1700	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; We had Provider placement form included in Medical profile sent to doctor and with missing documents from returned medical profile it may have been over looked so we have added the provider placement determination to the Marketing audit list so it can be checked off when reviewing all lease documentation for Assisted Living. See attached document - 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; Having added to the sales audit list where it will have to be checked off when received will ensure that we received and will be able to give to DRC	10/06/2023

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	that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to obtain a Physician Placement Determination Statement to determine the appropriate facility type and care for 3 of 10 sampled residents (Resident #2, #6, and #1). Findings include: Resident #2 Resident #2 was admitted to the facility on 03/03/23, with diagnoses including dementia, risk for falling, and cognitive defects. Resident #2's record included a Physician Placement Determination Statement dated 01/21/22, greater than a year before the resident's admission date. On 08/07/23 at 2:07 PM, the Director of Resident Care verbalized Resident #2 had come from the independent living side of the facility and the document was completed during the time the resident was a resident in independent living but a new document should have been completed prior to the resident admitting to the assisted living facililty. Resident #6 Resident #6 was admitted to the facility on 10/17/22, with diagnoses including osteoarthritis of knee, unspecified and history of falling. Resident #6's record lacked a Physican Placement		with Medical Profile to review before DRC meets prospective Assisted Living Resident. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; This will be reviewed and monitored by administrator and or Sales Director as part of resident qualifying for assisted living. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Administrator and or Sales Director 5) The date the corrective action will be completed; 10/06/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Having added to the sales audit list where it will have to be checked off when received will ensure that we received and will be able to give to DRC with Medical Profile to review before DRC meets prospective Assisted Living Resident.	

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	Determination Statement. On 08/07/23 at 2:37 PM, the Director of Resident Care confirmed the record for Resident #6 lacked a Physician Placement Determination Statement. Resident #1 Resident #1 was admitted to the facility on 05/13/15, with diagnoses including essential primary hypertension, mild cognitive impairment, and malignant neoplasm of colon, unspecified. Resident #1's record included a Physician Placement Determination Statement, undated, the form contained only the resident's name and was not dated, lacked a determination, and was not signed. On 08/07/23 at 2:38 PM, the Director of Resident Care confirmed the facility lacked documented evidence a Physician Placement Determination Statement had been completed for Resident #1. Severity: 2 Scope: 1			
1830 SS= F	Infection Control Required Training Inspector Comments: Based on personnel file review, document review, and interview, the primary and secondary infection control staff lacked the required infection control training. Findings include: On 08/07/23, the Accountant was provided the Personnel Check List to complete for 12 sampled employees. On 08/07/23, the Accountant provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 03/04/18. On 08/07/23, Employee #1's personnel file lacked the required infection control and prevention training required for the primary infection control staff. Employee #2 Employee #2 hired by the facility as Director of Resident Care with a start date of 02/09/23. On 08/07/23, Employee #2's personnel file lacked the required infection control and prevention training required for the primary infection control staff designee. On 08/07/23 in the afternoon, the Accountant provided the Attestation of Compliance form, signed and dated 08/07/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate	1830	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; We are working on our CDC infection Control training of17 1/2 hours and will have completed by October 30th. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; We will make part of the hiring process and orientation training to have completed in the first 30 days of hire for Administrators and Directors of resident care. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; This will be monitored by BOM/HR Director through the new hire process.	10/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	116	A. BUILDING _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3		4) The title of the person (position) responsible for ensuring the plan of correction is implemented; BOM / HR Director 5) The date the corrective action will be completed; 10/30/23 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; This will be part of new hire process and part of orientation and training schedule and course will need to be completed and certificate received to be acknowledged as complete and signed off by BOM/ HR Director	