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 _____	08/14/2024

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 08/14/2024. 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 and 20 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		
0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review and interview, the Administrator failed to ensure the facility maintained complete and accurate records for 1 of 10 residents (Resident #2). Finding include:	0053	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; On 8.14.24, the Director of Health & Wellness (DHW) called Sierra Nevada Home Health and requested a copy of the Home Health plan of care (POC) for Resident #2. A copy of the Home Health POC for Resident #2 was sent to the DHW on 8.14.24 and provided to	08/14/2024

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	Resident #2 Resident #2 was admitted to the facility on 04/04/2024, with diagnoses including type two diabetes mellitus and age-related osteoporosis without current pathological fractures. A list of residents documented Resident #2 received home health care services. Resident #2's record lacked a care plan completed by the home health care provider. On 08/14/2024 at 11:45 AM, the Director of Resident Care verbalized home health care agencies did not routinely provide the facility with care plans and had not since the Director of Resident Care started working at the facility approximately one and a half years prior. The Director of Resident Care explained Resident #2 began receiving home health care services approximately one week prior, but the facility did not retain the care plans completed by Resident #2's home health care agency. Severity: 2 Scope: 1		the State Surveyors for review on 8.14.24. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; A Home Health POC binder has been created and will be kept up to date with Home Health POCs. Additionally, DHW has created a notification letter, attached hereto as Tag 0053, Exhibit A, that will be sent out to every primary care provider requesting that they fax copies of all home health referrals/orders to our facility at the time they are written. Also, DHW has created a notification letter, attached hereto as Tag 0053, Exhibit B, that will be sent out to the local home health agencies alerting them to the State Regulation that requires copies of Home Health POCs be kept on site and requesting that copies of the POCs be faxed to the facility at time of resident admission to Home Health services. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; A dry erase board is kept in the medication room in Assisted Living that is used to document residents receiving Home Health and/or Hospice services. When Assisted Living staff is alerted to a resident being admitted to Home Health services, this information is documented on the dry erase board and updated frequently. Designated lead care staff is in charge of keeping the board up to date and reviewing the Home Health POC binder on a using the Weekly Department Operations Audit tool, attached hereto as Tag	

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			0053, Exhibit C. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 08/14/2024 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a weekly basis.	
0451 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to maintain the contents of a first aid kit. Findings include: On 08/14/2024, a review of the facility's Assisted Living wing's first aid supplies located in a cupboard of the medication room, revealed the kit lacked a cardiopulmonary resuscitation (CPR) device. The supplies did not include disposable gloves or a thermometer, which were located on a medication cart. On 08/14/2024 at 10:45 AM, the Director of	0451	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Director of Health and Wellness (DHW) and Executive Director (ED) will coordinate with the community first aid supplier, Safety On Site, to put together two portable first aid kits that includes a CPR mask, thermometer, and disposable gloves. This first aid kits will be accessible to all employees that are certified to provide first aid to residents. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: The portable first aid kits will be stored in a place that is designated for the first	11/01/2024

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	Resident Care confirmed the kit lacked a CPR device. Severity: 2 Scope: 1		aid kits and accessible to all employees that are certified to provide first aid to residents. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Safety On Site will provide a monthly service wherein they monitor and restock the portable first aid kit. Designated lead care staff will ensure the portable first aid kits are reviewed for expiration of supplies, sufficient supply of first aid products, and proper storage using the Weekly Department Operations Audit tool, attached hereto as Tag 0451, Exhibit A. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 11.1.2024 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a weekly basis.	
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of	0876	1) How you will correct the specific finding(s) stated in the Statement of	08/15/2024

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	facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure an Ultimate User Agreement was completed after a change of condition for 1 of 10 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 05/03/2022, with diagnoses including anxiety disorder and hypothyroidism. Resident#3's Ultimate User Agreement dated 11/17/2023, documented the resident would retain and self administer medications. On 08/14/2024 at 11:55 AM, the Director of Resident Care verbalized Resident #3 was independent and able to manage their medications when they admitted to the facility on 11/17/2023. In July of 2024, the resident had a need for the facility to take over administration of Resident #3's medication. The Director of Resident Care verbalized a new Ultimate User Agreement should have been completed for Resident #3 when the facility took over the management of the resident's medications. Resident #3's clinical record lacked documented evidence of an Ultimate User Agreement completed by the resident and/or the resident's power of attorney for the facility to possess and administer the resident's medications. On 08/14/2024 at 12:27 PM, the Director of Resident Care verbalized the facility did not have the resident complete a new Ultimate User Agreement when the facility took over the management of the resident's medications. Scope: 2 Severity: 1		Deficiencies; The Director of Health and Wellness (DHW) obtained an updated and signed Ultimate User Agreement for Resident #3 on 8.15.24, attached hereto as Tag 0876, Exhibit A. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: Designated lead care staff will complete an audit of the resident binders using the Monthly Department Operations Audit tool, attached hereto as Tag 0876, Exhibit B. The audit will identify areas in need of correction within the resident binders. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Designated lead care staff will identify and correct missing/updated documents, including the Ultimate User Agreements. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 8.15.24 and ongoing to maintain compliance	

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			6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a monthly basis.	
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or	0878	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Director of Health and Wellness (DHW)reviewed medication orders and MAR, sent requests for order clarification to the prescribing physician (s), and had the MAR updated, accordingly. Additionally, on 9.5.24 the DHW coordinated an in-person meeting with the facility's local Omnicare Pharmacy representative to review and update the MAR in real-time. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: Designated lead care staff will utilize the Weekly Medication Cart & MAR Audit tool, attached hereto as Tag 0878,Exhibit A, to identify and correct inconsistencies/discrepancies in the MAR and medication cart. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; During preparation of the upcoming monthly MAR, a designated lead care staff will review the previous monthly	11/01/2024

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	prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, and record review the facility failed to ensure a medication had a physician's order for 1 of 10 sampled residents (Resident #6) and a medication was onsite and available as prescribed for 1 of 10 sampled residents (Resident #7). Findings include: Resident #6 Resident #6 was admitted to the facility on 05/29/2024, with diagnoses including other secondary parkinsonism and macular degeneration. On 08/14/2024 at 2:07 PM, during the medication review and in the presence of a Medication Technician, a bottle of Aller-Flex (Fexofenadine Hydrochloride) 180 milligram (mg) tablets was stored with Resident #6's active medications. Resident #6's Medication Administration Record (MAR) contained the following: -Allergy Relief (Fexofenadine Hydrochloride) 180 mg tablet, take one tablet by mouth once a day as needed for allergies. -Aller-Flex 100 mg tablet, take one tablet by mouth once a day as needed for allergies. The Medication Technician verbalized Aller-Flex 100 mg tablets were not onsite however the Medication Technician was not sure which entry on the MAR for allergy relief was correct. Resident #6's record lacked a physician's order for Allergy Relief (Fexofenadine Hydrochloride) 180 mg tablets or Aller-Flex 100 mg tablets. On 08/14/2024 at 3:38 PM, the Director of Resident Care confirmed the facility lacked an order for Allergy Relief (Fexofenadine Hydrochloride) 180 mg tablets or Aller-Flex 100 mg tablets. The Director of Resident		MAR and active orders to ensure the MAR is correct and up to date. Additionally, the DHW will coordinate in-person meetings with the facility's local Omnicare Pharmacy representative, quarterly, to review and update the MAR in real-time. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 11.1.2024 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a weekly basis. Additionally, the DHW will coordinate an in-person quarterly meeting with the local Omnicare Pharmacy representative to review and update the MARs.	

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	Care explained a medication should not be onsite or added to the MAR without a current order. Resident #7 Resident #7 was admitted to the facility on 07/06/2024, with a diagnosis of Alzheimer's disease and dementia. Resident #7's MAR documented Loperamide 2 mg tablet, take two capsules by mouth after diarrhea, then one capsule by mouth after each loose stool. On 08/14/2024 at 2:31 PM, during the medication review, the Medication Technician verbalized the resident's Loperamide was not on the medication cart. Resident #7's physician order dated 08/14/2024, documented take two capsules by mouth after diarrhea, then one capsule by mouth after each loose stool. On 08/14/2024 at 3:32 PM, the Director of Resident Care confirmed the facility did not have Loperamide available to administer to Resident #7. Severity: 2 Scope: 1			
0895 SS= E	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication.	0895	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Director of Health and Wellness (DHW)reviewed medication orders and MAR, sent requests for order clarification to the prescribing physician (s), and had the MAR updated, accordingly. Finally, on 9.5.24 the DHW coordinated an in-person meeting with the facility's local Omnicare Pharmacy representative to review and update the MAR in real-time. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: Designated lead care staff will utilize the Weekly Medication Cart & MAR Audit tool, attached hereto as Tag 0895,Exhibit A, to identify and correct inconsistencies/discrepancies in the	11/01/2024

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	Inspector Comments: Based on observation, interview, and record review the facility failed to ensure a Medication Administration Record (MAR) was accurate for 4 of 10 sampled residents (Resident #7, #10, #3 and #9). Findings include: Resident #7 Resident #7 was admitted to the facility on 07/06/2024, with a diagnosis of Alzheimer's disease and dementia. Resident #7's MAR documented the following: -Acetaminophen 325 milligram (mg) tablet, take one to two tablets by mouth every six hours as needed for headache. -Acid Reducer 10 mg tablet, take one tablet by mouth twice daily as needed. -Polyethylene Glycol 3350, once daily, give 17 grams by mouth every day as needed for constipation. On 08/14/2024 at 2:31 PM, during the medication review, the Medication Technician verbalized the Resident #7's Acetaminophen, Acid Reducer, and Polyethylene Glycol was not on the medication cart. Resident #7's record lacked physician's orders for Acetaminophen, Acid Reducer, and Polyethylene Glycol. On 08/14/2024 at 3:32 PM, the Director of Resident Care confirmed the facility did not have physician's orders for Acetaminophen, Acid Reducer, and Polyethylene Glycol and those medication should not be listed on Resident #7's MAR. Resident #10 Resident #10 was admitted to the facility on 08/06/2021, with a diagnosis of Parkinson's disease. Resident #10's MAR documented Minconazole Nitrate 2 percent (%) powder, apply thin layer to affected area daily as needed for skin protection. On 08/14/2024 at 2:40 PM, during the medication review, the Medication Technician verbalized the Resident #10's Minconazole Nitrate was not on the medication cart and was in the resident's room for self administration. Resident #10's physician order dated 07/19/2024, documented Minconazole Nitrate 2 % powder, apply to groin rash twice a day as needed for rash. May keep in resident room. On 08/14/2024 at 3:32 PM, the Director of Resident Care confirmed the Resident #7's Minconazole Nitrate was documented on the MAR as an as needed medication and should have been documented as self (administration) on the		MAR and medication cart. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; During preparation of the upcoming monthly MAR, a designated lead care staff will review the previous monthly MAR and active orders to ensure the MAR is correct and up to date. Additionally, the DHW will coordinate in-person meetings with the facility's local Omnicare Pharmacy representative, quarterly, to review and update the MAR in real-time. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 11.1.2024 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a weekly basis. Additionally, the DHW will coordinate an in-person quarterly meeting with the local Omnicare Pharmacy representative to review and update the MARs.	

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	MAR. The Director of Resident Care confirmed the MAR inaccuracy. Resident #3 Resident #3 was admitted to the facility on 05/03/2022, with diagnoses including anxiety disorder and hypothyroidism. A physician's order dated 07/24/2024, documented Mirtazapine 15 mg tablet. Take 0.5 tablets by mouth every evening for mood, appetite, and sleep. A physician's order dated 08/04/2024 documented Mirtazapine 7.5 mg tablet. Take one tablet by mouth every evening for mood, appetite, and sleep. Resident #3's August 2024 MAR documented Mirtazapine 15 mg tablet. Take one half tablet (7.5mg) by mouth every night for mood, appetite, and sleep. On 08/14/2024 at 2:37 PM, during the medication review, a medication label documented Mirtazapine 7.5 mg. Take one tablet by mouth every evening for mood and appetite and sleep. The Medication Technician confirmed the label on the medication and the resident's MAR did not match. On 08/14/2024 at 4:29 PM, the Director of Resident Care explained the Mirtazapine order changed on 08/04/2024, and the August 2024 MAR should have been updated to reflect Resident #3's most current active order. Resident #9 Resident #9 was admitted to the facility on 04/28/2024, with diagnoses including chronic pain and peripheral vascular disease. On 08/14/2024 at 2:15 PM, during the medication review and in the presence of a Medication Technician, the following medication was with Resident #9's active medications and was not on the MAR. - Simethicone (Gas-X) 125 milligrams (mg) chewable tablets. On 08/14/2024 at 2:45 PM, the Director of Resident Care reviewed Resident #9's record and confirmed the facility had an order for Simethicone 125 mg chewable tablets and the medication should have been on the resident's MAR. Severity: 2 Scope: 2			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The	0920	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Director of Health and Wellness (DHW) and Executive Director (ED)	12/01/2024

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	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 for 7 of 16 resident rooms with a resident self-administering medications (Rooms #143, #150, #154, #155, #157, #163, and #176). Findings include: On 08/14/2024, the following resident rooms contained unsecured medications: 1) Room #143 -A shared room, one resident self-administered medications and the other resident was on medication management. The self-administered medications were stored in an open basket in the unsecured bedroom. 2) Room #150 - At 9:53 AM, the resident of Room #150 verbalized the Toxic medications were secured in a locked cabinet. The Non-Toxic prescription medications were located on top of the microwave in the kitchen. The resident verbalized not always locking the door when out of the room. 3) Room #154 - At 10:03 AM, the room was discovered unlocked. The prescription medications were located in an unsecured medicine cabinet located in the bathroom. 4) Room #155 - A shared room, one resident self-administered medications and the other resident was on medication management. The room was discovered unlocked. Over the Counter (OTC) medication was on the counter of the kitchen. Prescription medications were located in an unlocked drawer in a		have drafted a notification letter, attached hereto as Tag 0920, Exhibit A. This notification letter will be hand delivered to the residents who have been non-compliant with State Regulation regarding safe medication storage, alerting them to the citation that was received during the 8.14.24 State Survey as a result of their non-compliance. Upon delivery of the notification letter, the DHW and ED will advise the residents that medication management will be initiated and required for them subsequent to an additional, documented occurrence of non-compliance. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur; Designated lead care staff will monitor compliance with safe medication storage for the residents that manage their own medications utilizing the Weekly Department Operations Audit tool, attached hereto as Tag 0920, Exhibit B. Following the first occurrence of non-compliance, the resident will be reminded of the State Regulation regarding safe medication storage and given a first and final warning to be compliant. Occurrences of non-compliance will be documented on the Weekly Department Operations Audit tool and reported to the DHW. If a resident is non-compliant after the first occurrence, the DHW will initiate medication management for that resident moving forward. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur;	

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	bedroom. 5) Room #157 - A shared room, one resident self-administered medications and the other resident was on medication management. OTC medication was on the counter of the kitchen. 6) Room #163 - At 10:20 AM, the resident verbalized the door was not always locked when out of the room. A prescription medication was located on the kitchen counter. 7) Room #176 - At 10:30 AM, the Director of Resident Care verbalized the resident of Room #176's hands had impaired dexterity, resulting in the resident leaving prescription medication bottles open and unsecured in the bedroom. Due to the impaired dexterity, the resident rarely locked the door when out of the room. On 08/14/2024 at 10:11 AM, the Director of Resident Care verbalized most residents do not secure their medications or lock their doors when out of their rooms. The Director of Resident Care also verbalized all medications needed to be adequately secured in the room. The facility policy titled, "Medication Management," revised 06/09/2023 documented, "F. 1. Residents who engage in self-administration of medications may store medications in a secure area in their apartment." Severity: 2 Scope: 3		An Acknowledgement Regarding Safe Medication Storage, attached hereto as Tag 0920, Exhibit C, has also been drafted. This acknowledgement form will be disseminated to existing Assisted Living residents for immediate review and signature and to future Assisted Living residents to be reviewed and signed with leasing agreement. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 12.1.2024 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a weekly basis.	
0923 SS= A	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 and interview, the facility failed to ensure an over-the-counter (OTC) medication bottle contained the prescriber's name for 1 of 10 sampled residents (Resident #6). Findings	0923	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; On 8.14.24, the Director of Health and Wellness (DHW) reviewed the OTC packaging in both medication carts and ensured labeling was accurate for Resident #6. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not	08/14/2024

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	include: Resident #6 Resident #6 was admitted to the facility on 05/29/2024, with diagnoses including other secondary parkinsonism and macular degeneration. On 08/14/2024 at 2:07 PM, during the medication review and in the presence of a Medication Technician, a bottle of MiraLax (Polyethylene Glycol) was with Resident #6's active medications. The bottle lacked the prescriber's name. On 08/14/2024 at 2:10 PM, the Medication Technician confirmed the bottle of MiraLax lacked the prescriber's name. Severity: 1 Scope: 1		recur: Designated lead care staff will utilize the Weekly Medication Cart & MAR Audit tool, attached hereto as Tag 0923, Exhibit A, to identify and correct inconsistencies/discrepancies in the MAR and medication cart. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; On 8.14.24, department staff were re-educated regarding OTC labeling requirements. Since this resident's family supplies the OTC medications for this resident and only one of his medications is provided by the pharmacy in pharmacy packaging (blister packs), the DHW asked the resident's family if they would allow the resident's OTC medications to be provided by Omnicare Pharmacy. The resident's family refused. 4) The title of the person (position)responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 8.14.24 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice;	

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			Utilizing the audit tool, areas in need of correction will be identified and addressed on a weekly basis.	
1100 SS= E	Weights - Training/Consent - NAC 449.1985 (4) 4. A caregiver may weigh a resident of a residential facility only if: (a) The caregiver has received training on the manner in which to weigh a person that meets the requirements of subsections 5 and 6; and (b) The resident has consented to being weighed by the caregiver. Inspector Comments: Based on record review and interview, the facility failed to obtain resident or resident representative consent to obtain monthly resident weight measurements from the facility census. Findings include: On 08/14/2024 at 11:54 AM, the Administrator verbalized caregiver staff members obtained weight measurements from all residents on a monthly basis. On 08/14/2024 at 2:28 PM, the Director of Resident Care confirmed all residents weight measurements were taken monthly and the facility had not obtained consents for weight measurements from any resident or resident representative. The Director of Resident Care verbalized not having been aware of this requirement. Severity: 2 Scope: 2	1100	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Director of Health and Wellness (DHW) and Executive Director (ED) were informed by State surveyors on 8.14.24 that “written” consent to measure a resident’s weight must be obtained from the resident or their representative. The DHW and ED are not certain based upon the information contained in the statement of deficiency if “written” consent is required. When resident weights are collected, facility care staff advise the residents that monthly weights are required per company policy and they ask for permission to collect a weight. If the resident agrees to be weighed, verbal consent has been received. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: Designated lead care staff will complete an audit of the resident binders using the Monthly Department Operations Audit tool, attached hereto as Tag 1100, Exhibit A. The audit will identify areas in need of correction within the resident binders. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur;	12/01/2024

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			An Acknowledgement Regarding Monthly Weight Collection, attached hereto as Tag 1100, Exhibit B, has also been drafted. This acknowledgement form will be disseminated to existing Assisted Living residents for immediate review and signature and to future Assisted Living residents to be reviewed and signed with leasing agreement. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 12.1.2024 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a monthly basis.	
1400 SS= C	Duties of licensed facility to protect - NRS 449.102 Duties of licensed facility to protect privacy of patient or resident. [Effective January 1, 2020.] A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: 1. Maintain the confidentiality of personally identifiable information concerning the sexual orientation of a patient or resident, whether the patient or resident is transgender or has undergone a gender transition and the human immunodeficiency virus status of the	1400	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Executive Director (ED) has submitted a copy of the Statement of Deficiencies (SOD) to the regional corporate representatives to review and address. It is anticipated that the existing policy will be modified to incorporate the language required by	01/01/2025

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	patient or resident and take reasonable actions to prevent the unauthorized disclosure of such information; 2. Prohibit employees or independent contractors of the facility who are not performing a physical examination or directly providing care to a patient or resident from being present during any portion of the physical examination or care, as applicable, during which the patient or resident is fully or partially unclothed without the express permission of the patient or resident or the authorized representative of the patient or resident; 3. Use visual barriers, including, without limitation, doors, curtains and screens, to provide privacy for patients or residents who are fully or partially unclothed; and 4. Allow a patient or resident to refuse to be examined, observed or treated by an employee or independent contractor of the facility for a purpose that is primarily educational rather than therapeutic Inspector Comments: Based on interview and document review of the policy titled "Right to Receive Notice of Privacy Practices," revised 11/01/2018, the facility failed to create measures to: (1) maintain the confidentiality of personally identifiable information concern sexual orientation, gender identity, and HIV (human immunodeficiency virus) status of a resident, (2) prohibit employees or independent contractors who are not performing a physical exam or directory providing care to a resident from being present during any portion of examination or care, (3) use of physical barriers to provide privacy for residents who are fully or partially unclothed, and (4) allowing a resident to refuse to be examined, observed, or treated by an employee or contractor of the facility for a purpose that is primarily educational rather than therapeutic. Findings include: On 08/14/2024, the Administrator was unable to provide other policies related to the protection of confidentiality of sexual orientation, gender identity or HIV status of a resident, or for the physical privacy of a resident. Severity: 1 Scope: 3		law. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: The designated/responsible company representatives will modify the existing policy to incorporate the language required by law. Additionally, if intake forms and leasing documents need to be modified to correlate with the updated policy, those forms and documents will be modified accordingly. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; The modified policy, forms, and documents will replace the deficient policy, forms, and documents. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Designated/responsible corporate representatives 5) The date the corrective action will be completed; 1.1.25 - pending action to be taken by designated/responsible corporate representatives and ongoing to ensure compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice;	

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			Adhere to the modified policy and utilize the modified forms and documents once initiated.	
1540 SS= D	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the Department or his or her designee pursuant to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program	1540	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Executive Director (ED), Director of Health and Wellness (DHW), and Human Resources (HR) Director are coordinating with the training agency, High Sierra AHEC, to enroll all English speaking employees in the Nevada Cultural Competency online course. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: The HR Director or designee will review employee compliance with Nevada Cultural Competency training on a monthly basis utilizing the Employee State Training Compliance Tickler, attached hereto as Tag 1540, Exhibit A. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; The HR Director or designee will review employee compliance with Nevada Cultural Competency training on a monthly basis utilizing the Employee State Training Compliance Tickler, attached hereto as Tag 1540, Exhibit A.	01/01/2025

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	submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 15 3. When a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without		4) The title of the person (position)responsible for ensuring the plan of correction is implemented; The HR Director and/or designee. 5) The date the corrective action will be completed; 1.1.25 and ongoing to ensure compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the Employee State Training Compliance Tickler, areas in need of correction will be identified and addressed on a monthly basis.	

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	limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of the course or program to print and sign his or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec. 15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a			

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	person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4 of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by federal, state or local government agencies; or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility			

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	116	A. BUILDING _____ B. WING _____	08/14/2024

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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	needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not received or fails to include all of the information that the Director or his or her designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 6 of 20 sampled employees required to obtain cultural competency training (Employees #11, #12, #13, #14, #17, and #20). Findings include: On 08/14/2024, the Business Office Manager was provided the Personnel Check List to complete for 20 sampled employees. On 08/14/2024, the Business Office Manager provided the completed form with the following information: Employee #11 Employee #11 was hired by the facility as a Life Enrichment Associate with a start date of 05/23/2019. On 08/14/2024, Employee #6's personnel file lacked a cultural competency training certificate. Employee #12 Employee #12 was hired by the facility as a Resident Services Associate with a start date of 07/02/2024. On 08/14/2024, Employee #12's personnel file lacked a cultural competency training certificate. Employee #13 Employee #13 was hired by the facility as a Caregiver with a start date of 12/19/2023. On 08/14/2024, Employee #13's personnel file lacked a cultural competency training certificate. Employee #14 Employee #14 was hired by the facility as a Resident Services Associate with a start date of 09/08/2014. On 08/14/2024, Employee #14's personnel file lacked a cultural competency training certificate. Employee #17 Employee #17 was hired by the facility as a Lifestyle Program Director with a start date of 08/03/2009. On 08/14/2024, Employee #17's personnel file			

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	lacked a cultural competency training certificate. Employee #20 Employee #20 was hired by the facility as a Resident Services Associate with a start date of 01/06/2021. On 08/14/2024, Employee #20's personnel file lacked a cultural competency training certificate. On 08/14/2024 at 3:35 PM, the Administrator confirmed only caregiver staff had received cultural competency training. On 08/14/2024 in the afternoon, the Business Office Manager provided the Attestation of Compliance form, signed and dated 08/14/2024, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. Severity: 2 Scope: 1			
1600 SS= D	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or	1600	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Executive Director (ED) has submitted a copy of the Statement of Deficiencies (SOD) to the regional corporate representatives to review and address. It is anticipated that the existing policy will be modified to incorporate the language required by law. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: The designated/responsible company representatives will modify the existing policy to incorporate the language required by law. Additionally, if intake forms and leasing documents need to be modified to correlate with the updated policy, those forms and documents will be modified accordingly.	01/01/2025

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	resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on document review and interview, the facility failed to develop policies to ensure a resident was addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression. Finding include: On 08/14/2024 at 4:06 PM, the Director of Resident Care confirmed the facility had not developed policies to ensure a resident would be addressed by the resident's preferred name and pronoun in accordance with the resident's gender identity or expression. The Director of Resident Care verbalized not having been		3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; The modified policy, forms, and documents will replace the deficient policy, forms, and documents. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; Designated/responsible corporate representatives 5) The date the corrective action will be completed; 1.1.25 – pending action to be taken by designated/responsible corporate representatives and ongoing to ensure compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Adhere to the modified policy and utilize the modified forms and documents once initiated.	

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	aware of this requirement. Severity: 2 Scope: 1			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident 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	1700	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies; The Director of Health and Wellness (DHW) received a Physician's Report for Residential Care Facilities for the Elderly from the California Department of Social Services, attached hereto as Tag 1700, Exhibit A, prior to resident's move-in. The DHW and the Executive Director (ED) reviewed the submitted forms and determined that these forms were filled out adequately to indicate that the physician had determined the resident was appropriate for placement in an Assisted Living setting despite having a diagnosis of dementia. Please note that Resident #7 has moved to a memory care facility since the date of State Survey. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur: Designated lead care staff will complete an audit of the resident binders using the Monthly Department Operations Audit tool, attached hereto as Tag 1700, Exhibit B. The audit will identify areas in need of correction within the resident binders. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; The DHW will not allow out-of-state forms to be used to meet this	10/01/2024

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	resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the facility failed to obtain an initial Standard Physician Assessment and Placement Determinations for 1 of 10 sampled residents with a diagnosis of dementia (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 07/06/2024, with a diagnosis of Alzheimer's and dementia. Resident #7's record lacked a Standard Placement Determination.. On 08/14/2024 at 12:27 PM, the Director of Resident Care verbalized Resident #7 did not have a Standard Placement Determination and should have had one upon admission. Severity: 2 Scope: 1		requirement, despite her belief that those forms are adequate to meet the requirement. Instead, the DHW will obtain the Appropriate Provider Placement Determination to ensure compliance. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented; The DHW and/or designee. 5) The date the corrective action will be completed; 10.1.24 and ongoing to maintain compliance 6) How you will identify and correct other areas having potential to be affected by the same deficient practice; Utilizing the audit tool, areas in need of correction will be identified and addressed on a monthly basis.	