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 _____	09/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual completed at your facility on 09/11/2025. The facility is licensed for s45 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. Ten resident files and 15 employee files were reviewed. The facility received a grade of D.			

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Y 0051 SS= C	**NAC 449.194** 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. Inspector Comments: Inspector Comments: Based on observation and interview, the facility failed to ensure posting of the administrator and the assigned designee were posted in a public area. Findings include: On 09/11/2025 at 11:45 AM, the Director of Assisted Living verbalized there was no public posting of the Administrator and Designee in a public area of the facility. No posting was observed during the tour of the facility.	Y 0051	1. Posting of the administrator and the assigned designee were posted in a public area on date of survey visit, 09/11/2025. 2. Daily form to be completed by Concierge to verify and ensure posting is present and accurate. 3. Executive Director to review Daily Administrator/Designee Posting as part of Weekly Health Services Meeting 4. Executive Director 5. Completed on date of survey, 09/11/2025 6. Concierge Daily Administrator/Designee Posting Verification, Weekly Health Services Meeting Agenda	09/11/2025
Y 0065		Y 0065	1. Complete employee training record	01/09/202

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SS= D	**NAC 449.196 & R043-22** **Qualifications of caregivers:** 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156to 449.27706,inclusive, *and sections 2 to 16,inclusive, of this regulation* and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and *(f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility;* and *(g)*Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training *must include, without limitation, at least 2 hours of tier 2 training.* Inspector Comments: Based on interview and personnel file review, the facility failed to ensure 3 of 15 sampled employees obtained timely initial and annual caregiver training (Employee #1, #8 and #15).		audit for active caregiver employees to identify those missing initial and annual trainings. Employees identified with missing training will be required to complete training prior to next work day. 2. Tickler spreadsheet set up for employee due date tracking, email reminders sent to employees in the month prior to due date. Executive Director to review new hire training checklists for completion within 30 days of hire. Annual training records to be audited by Executive Director or designee within 30 days of anniversary date. 3. Executive Director and Business Office Director to conduct monthly audit of caregiver training records to ensure compliance with initial and annual training requirements. 4. Executive Director 5. 1/9/2026 6. Employee Record Audit 7. In audit of employee files, will review additional requirements to ensure compliance. Employee #8 has expired.	6

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	Findings include: Employee # 1 Employee #1 was hired as the Administrator on 02/17/2025. Employee #1's personnel file documented four hours of initial caregiver training completed more than 30 days after hire. Employee #8 Employee #8 was hired as a caregiver on 01/25/2024. Employee #8's personnel file documented only seven hours of annual caregiver training completed. Employee #15 Employee #15 was hired by the facility as a Medication Technician with a start date of 06/24/2025. Employee #15's personnel file lacked documented evidence of initial caregiver training completed within the first 30 days of hire. On 09/11/2025 at 11:55 AM, the Administrative Assistant confirmed Employee #1's four hours of initial caregiver training was completed late and Employee #8 had not completed the required eight hours of annual training and Employee #15's initial caregiver training was not completed. Severity: 2 Scope: 1			
Y 0074 SS= D	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must	Y 0074	1. Complete employee training record audit for active employees to identify those missing initial and annual training. Employees identified with missing training will be required to complete training prior to next work day. 2. Tickler spreadsheet set up for	01/09/2026

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	receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually receive training to recognize and prevent theabuse of older persons before the license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse of older persons before the facility, agency or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care, facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter.		employee due date tracking, email reminders sent to employees in the month prior to due date. Executive Director to review new hire training checklists for completion within 30 days of hire. Annual training records to be audited by Executive Director or designee within 30 days of anniversary date. 3. Executive Director and Business Office Director to conduct monthly audit of caregiver training records to ensure compliance with initial and annual training requirements. 4. Executive Director 5. 1/9/2026 6. Employee Record Audit 7. In audit of employee files, will review additional requirements to ensure compliance. Employee #12 no longer employed	

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	6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, 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, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section. 8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection.			

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	9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on personnel file review, document review, and interview, the Administrator failed to ensure 3 of 15 sampled employees received timely initial elder abuse prevention training (Employee #4, #11 and#12). Findings include: Employee #4 was hired as a Caregiver with a start date of07/14/2025. Employee #4's personnel record lacked documented evidence of elder abuse training completed. Employee #11 was hired as a Medication Technician with a start date of 06/23/2025. Employee #11's personnel record lacked documented evidence of elder abuse training completed. Employee #12 was hired as a Medication Technician with a start date of 06/23/2025. Employee #12's personnel record documented initial elder abuse training completed on 06/08/2024; however, lacked documented evidence of annual elder abuse completed in 2025. On 09/11/2025 at 11:55 AM, the Administrative Assistant confirmed the elder			

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	abuse training for Employee #4 #11 and #12 was not completed. The Executive Administrator Assistant verbalized elder abuse training was to be completed 30 days upon hire and annually thereafter and was unaware elder abuse training was to be completed upon hire. Severity: 2 Scope: 1			

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Y 0102 SS= D	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 15 sampled employees met the requirements concerning tuberculosis(TB) testing. (Employee #6 and #9). Findings include: Employee #6 was hired as a Medication Technician with a start date of 09/01/2022. Employee #6's personnel file contained a TB QuantiFERON test dated 10/02/2023; however, lacked a TB test for 2024. Employee #9 was hired as a Medication Technician with a start date of 12/07/2023. Employee #9's personnel file contained a TB QuantiFERON test dated 10/11/2023; however, lacked a TB test for 2024. On 09/11/2025 at 11:55 AM, the Administrative Assistant confirmed Employee #6 and #9's personnel record lacked documented evidence of a TB test being completed in 2024. Severity: 2 Scope: 1	Y 0102	1. Complete employee record audit for active employees to identify those missing initial and annual TB testing documentation. Employees identified with missing documentation will be required to complete within 30 days. 2. Tickler spreadsheet set up for employee due date tracking, email reminders sent to employees in the month prior to due date. Executive Director to review new hire checklists for completion within 30 days of hire. Annual training records to be audited by Executive Director or designee within 30 days of anniversary date. 3. Executive Director and Business Office Director to conduct monthly audit of caregiver training records to ensure compliance with initial and annual training requirements. 4. Executive Director 5. 1/9/2026 6. Employee Record Audit 7. In audit of employee files, will review additional requirements to ensure compliance.	01/09/2026

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Y 0106 SS= D	NAC 449.0113 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. Inspector Comments: Based on record review and interview, the facility failed to ensure employees obtained timely first aid and cardiopulmonary resuscitation(CPR) training for 1 of 15 sampled employees, working at the facility greater than 30 days (Employee #3). Findings include: Employee #3 Employee #3 was hired by the facility as Medication Technician with a start date of 07/14/2025. Employee #3's personnel file lacked documented evidence of a first aid and CPR training certificate. On 09/11/25 at 11:57 AM, the Administrative Assistant confirmed Employee #3's personnel record lacked a first aid and CPR training certificate. Severity: 2 Scope: 1	Y 0106	1. Complete employee record audit for active employees to identify those missing initial and annual CPR training documentation. Employees identified with missing documentation will be required to complete within 30 days. 2. Tickler spreadsheet set up for employee due date tracking, email reminders sent to employees in the month prior to due date. Executive Director to review new hire checklists for completion within 30 days of hire. 3. Executive Director and Business Office Director to conduct monthly audit of caregiver training records to ensure compliance with initial and annual training requirements. 4. Executive Director 5. 1/9/2026 6. Employee Record Audit. 7. In audit of employee files, will review additional requirements to ensure compliance. Employee #3 no longer employed.	01/09/2026
Y 0515 SS= D	NAC 449.259	Y 0515	1. Community transitioned to new management company on 9/24/2025. All residents have to	01/09/2026

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	Supervision of residents. 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and		have updated service plans entered into new program by 01/09/2026. 2. Community transitioned to new management company with new EHR software. Software automates due dates and reminders. Upcoming due dates to be discussed in weekly health services meeting with Health & Wellness Director and Executive Director. 3. Weekly Health Services meeting agenda to include review of annual service plans due and completion. 4. Executive Director, Health & Wellness Director 5. 1/9/2026 6. Weekly Health Services Meeting Agenda	

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	unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to ensure an annual person-centered service plan was completed for 2 of 10 residents (Resident #2, and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 06/05/2024, with diagnoses including hypothyroidism, hypertension, and shortness and acid reflux. Resident #2's record documented an initial person-centered service plan dated 06/05/2024. Resident #2's record lacked documented evidence of a completed annual person-centered service plan for 2025. Resident #3 Resident #3 was admitted to the facility on 09/02/2024, with diagnoses including dementia, glaucoma, and anemia. Resident #3's record documented an initial person-centered service plan dated 09/02/2024. Resident #3's record lacked documented evidence of a completed annual person-centered service plan for 2025. On 09/11/2025 at 2:24 PM, the Administrator confirmed the missing annual person-centered service plan for Resident #2 and Resident #3 and acknowledged the service plan should have been updated annually.			

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	Severity: 2 Scope: 1			
Y 0850 SS= D	NAC 449.274 and R043-22 **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.** 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident.	Y 0850	1. Audit of all resident charts for annual physical examination. For residents with findings out of compliance, community will reach out to provider to schedule physical examination within 45 days. 2. Spreadsheet created to include tracking of annual physical exam due dates. Upcoming due dates to be discussed in weekly health services meeting with Health & Wellness Director and Executive Director. 3. Weekly Health Services meeting agenda to include review of annual physical examinations due and completion. 4. Executive Director, Health & Wellness Director 5. 1/25/2026 6. Weekly Health Service Meeting Agenda	01/25/2026

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	116	A. BUILDING _____ B. WING _____	09/11/2025

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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	This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident.			

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	Inspector Comments: Based on record review and interview, the facility failed to ensure a physical examination was completed annually for 2 of 10 residents (Resident #2, and #3). Resident #2 Resident #2 was admitted to the facility on 06/05/2024, with diagnoses including hypothyroidism, hypertension, and shortness and acid reflux. Resident #2's record documented a general physical exam with a review of systems dated 06/05/2024. Resident #2's clinical record lacked documented evidence a general physical exam with a review of systems was completed in 2025, four months late. Resident #3 Resident #3 was admitted to the facility on 09/02/2024, with diagnoses including dementia, glaucoma, and anemia. Resident #3's record documented a general physical exam with a review of systems dated 08/08/2024. Resident #3's clinical record lacked documented evidence a general physical exam with a review of systems was completed in 2025, one month late. On 09/11/2025 at 1:56 PM, the Administrator confirmed Resident #2 and Resident #3's record lacked documented evidence of an annual physical examination. Severity: 2 Scope: 1			
Y 0870 SS= E	NAC 449.2742 Administration of medication:	Y 0870	1. Audit of all resident charts for medication review every 6 months. For residents with findings out of compliance, community will reach out to provider to for completion	01/25/2026

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	Responsibilities of 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		within 45 days. 2. Spreadsheet created to include tracking of medication review every 6 months due dates. Upcoming due dates to be discussed in weekly health services meeting with Health & Wellness Director and Executive Director. 3. Weekly Health Services meeting agenda to include review of medication reviews coming due and completion. 4. Executive Director, Health & Wellness Director 5. 1/25/26 6. Weekly Health Service meeting agenda	

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submitted pursuant to paragraph (a).

Inspector Comments:

Based on medical record review and interview, the facility failed to ensure a review of residents' medications was conducted at least once every six months by a physician, pharmacist, or registered nurse for 2 of 10 sampled residents (Resident #9 and #10).

Findings include:

Resident #9

Resident #9 was admitted to the facility on 04/28/2024, with diagnoses including low back pain, urinary tract infection, and lethargy.

Resident #9's clinical record lacked documented evidence a medication review had been completed and signed by the provider.

Resident #10

Resident #10 was admitted to the facility on 03/30/2024,with diagnoses including cerebral infarction, diabetes mellitus type II, and hyperlipidemia.

Resident #10's clinical record lacked documented evidence a medication review had been completed and signed by the provider.

On 09/11/2025 at 11:23 AM, the Administrator confirmed the clinical records for Resident #9 and Resident #10 did not contain a medication review conducted at least once every six months by a physician, pharmacist, or registered nurse. The

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	Administrator explained residents residing in the facility for over six months were required to have a medication review by a physician, pharmacist, or registered nurse. Severity: 2 Scope:1			
Y 0930 SS= E	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he 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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him.	Y 0930	1. Audit of all resident charts for annual TB testing and ADL Assessment. Community to schedule third party vendor to complete QuantiFERON for all residents out of compliance within 45 days. Community transitioned to new management company on 9/24/2025. All residents have assessments entered into new program. 2. Spreadsheet created to include tracking of TB testing and ADL assessment due dates. Upcoming due dates to be discussed in weekly health services meeting with Health & Wellness Director and Executive Director. 3. Weekly Health Services meeting agenda to include review of annual TB testing and ADL assessments coming due and completion. 4. Executive Director, Health & Wellness Director 5. 1/25/2026 6. Weekly Health Service meeting agenda Resident #6 moved out	01/25/2026

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	(c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation:			

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	(1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person			

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responsible for the resident was contacted to inform him of the death.

3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau.

Inspector Comments:

Based on record review, interview, and document review the facility failed to ensure 4 of 10 sampled residents met the requirements concerning initial and annual tuberculosis (TB) testing in accordance with the Nevada Administrative Code (NAC) 441A (Resident #2, #3, #6 and #9) and annual Activities of Daily Living (ADL) Assessment was completed for 2 of 10 residents (Resident #2, and #3).

Findings include:

TB

Resident #2

Resident #2 was admitted to the facility on 06/05/2024, with diagnoses including hypothyroidism, hypertension, and shortness and acid reflux.

Resident #2's record documented an initial two step TB test completed on 06/07/2024 and lacked documented evidence of a TB test completed in 2025.

Resident #3

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	Resident #3 was admitted to the facility on 09/02/2024, with diagnoses including dementia, glaucoma, and anemia. Resident #3's record documented completed QuantiFERON blood test on 09/01/2024 and lacked documented evidence of a TB test completed in 2025. Resident #6 Resident #6 was admitted to the facility on 07/28/2025, with diagnoses including hyperlipidemia, essential hypertension, and shortness of breath. Resident #6's record lacked documented evidence of a TB test completed prior to 07/28/2025. Resident #9 Resident #9 was admitted to the facility on 04/28/2024, with diagnoses including low back pain, urinary trat infection, and lethargy. Resident #9's record documented completed QuantiFERON blood test on 04/05/2024 and lacked documented evidence of a TB test completed in 2025. On 09/11/2025 at 3:11 PM, the Administrator verbalized Resident#6 did not have a documented TB test prior to admission and Resident #9 did not have a documented annual TB test since 2024. The Administrator confirmed the lack of timely TB tests for Resident #2, #3, #6 and Resident #9. Activities of Daily Living Resident #2 Resident #2 was admitted to the facility on 06/05/2024, with diagnoses including hypothyroidism, hypertension, and shortness and acid reflux. Resident #2's file documented an annual			

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	assessment dated 06/05/2024; The record lacked an ADL assessment for 2025. Resident #3 Resident #3 was admitted to the facility on 09/02/2024, with diagnoses including dementia, glaucoma, and anemia. Resident #3's file documented an annual assessment dated 08/08/2024; The record lacked an ADL assessment for 2025. On 09/11/2025 at 2:59 PM, the Administrator verbalized ADL assessments are to be completed annually for each resident; however, was not completed for Resident #2, and Resident #3. Severity: 2 Scope: 2			
Y 0920 SS= E	NAC 449.2748 Medication Storage. 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 without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.	Y 0920	1. Health & Wellness Director or designee to visit and observe secured and unsecured medications in random resident apartments to ensure security of medications. Lockboxes have been provided to all residents who manage their medications independently. 2. Health & Wellness Director or designee to visit and observe secured and unsecured medications in resident apartments weekly. Visits will be documented on Self-Med audit sheet. Any deficient practice of unsecured medications to be corrected in real time. 3. Weekly Health Services meeting agenda to include review of weekly Self-Med audits and discuss any need for change in resident medication management. 4. Health & Wellness Director or designee 5. 1/9/2026 6. Self-Med Audit Sheet, Weekly Health Services Meeting Agenda Room#147 moved out	01/09/2026

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	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. 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: Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 3 of 12 resident rooms with a resident self-administering medication (Rooms #147, #164, and #167). Findings include: On 09/11/2025, the following resident rooms contained unsecured medications: 1) Room #147 – At 1:00 PM, the resident verbalized prescription medications were kept in two separate locked boxes in a storage closet, one for the resident and the other for the spouse. The resident also verbalized staff had taken several over-the-counter (OTC) medications from the storage closet about an hour prior to the interview. Other unsecured OTC medications were observed in the bathroom, including: Gas Ex, Pepto Bismol, Ducalax, and Delsym.		Room#164 moved out	

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	2) Room #164 at 10:59 AM, the resident in Room#164 verbalized the room door was not always locked when leaving. Benadryl was stored in the unlocked medicine cabinet. 3) Room #167 at 11:03 AM, the resident in Room#167 verbalized medications were stored in a zippered medication case with no lock. The resident didn't always lock the room door when out, and the Resident's roommate potentially had access to the unlocked medication case. On 09/11/2025 At 1:10 PM, the Director of Assisted Living verbalized all medications, including OTC medications need to be secured. Severity 2 Scope 2			
Y 0874 SS= E	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. <u>The report must be reviewed and initialed by the administrator.</u> Inspector Comments: Based on clinical document review, record review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, was reviewed and initialed by the	Y 0874	1. Audit of all resident charts for medication review every 6 months to include Administrator review within 72 hours of receipt. For residents with findings out of compliance, community will reach out to provider to for completion within 45 days with Administrator to review within 72 hours of receipt. 2. Spreadsheet created to include tracking of medication review every 6 months due dates with Administrator review within 72 hours. Upcoming due dates and completion to be discussed in weekly health services meeting with Health & Wellness Director and Executive Director. 3. Weekly Health Services meeting agenda to include review of medication reviews coming due and completion with Administrator signature. 4. Executive Director, Health & Wellness Director 5. 1/25/2026 6. Weekly Health Service meeting agenda	01/25/2026

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	Administrator within 72 hours for 2 of 10 sampled residents residing in the facility for longer than six months and requiring a six month medication profile review (Resident #9 and #10). Findings include: Resident #9 Resident #9 was admitted to the facility on 04/28/2024, with diagnoses including low back pain, urinary tract infection, and lethargy. Resident #9's clinical record lacked documented evidence a medication review had been reviewed and initialed by the Administrator. Resident #10 Resident #10 was admitted to the facility on 03/30/2024, with diagnoses including cerebral infarction, diabetes mellitus type II, and hyperlipidemia. Resident #10's clinical record lacked documented evidence a medication review had been reviewed and initialed by the Administrator. On 09/11/2025 at 11:25 AM, the Administrator confirmed the clinical records for Resident #9 and Resident #10 did not contain a medication profile review that was reviewed and initialed by the Administrator within 72 hours of completion. The Administrator explained all resident medication profiles were to be reviewed and initialed by the Administrator within 72 hours of completion. Severity:2 scope:1			
Y 1825		Y 1825	1. Health & Wellness Director and the	09/16/202

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FIVE STAR PREMIER RESIDENCES OF RENO	3201 PLUMAS STREET, RENO, NEVADA ,89509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS= F	**NAC 449.0109 Designation and training of person responsible for infection control.** 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training.		Assistant Health & Wellness Director, have since both completed the required CDC infection control training. 2. Tickler spreadsheet set up for employee due date tracking, email reminders sent to employees in the month prior to due date. Executive Director to review new hire checklists for completion within 30 days of hire. Annual training records to be audited by Executive Director or designee within 30 days of anniversary date. 3. Executive Director and Business Office Director to conduct monthly audit of training records to ensure compliance with initial and annual training requirements. 4. Executive Director 5. 9/16/2025 6. Employee Record Audit	5

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 _____	09/11/2025

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	Inspector Comments: Based on personnel file review, document review, and interview, the primary and secondary infection control person lacked the required infection control training potentially affecting 61 of 61 residents. Findings include: On 09/19/23 at 10:27 AM, the personnel files for the Wellness Director, the primary infection control person, and the Assistant Wellness Director, the designee lacked documented evidence of 15 hours of training concerning the control and prevention of infectious disease from the approved nationally recognized organizations. The Administrative Assistant confirmed the required infection control and prevention training had not been completed. Severity: 2 Scope: 3			
Y 1300 SS= C	**Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.]** 1. 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 and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. 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: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations	Y 1300	1. New management company, WellQuest Living, has non-discrimination policy listed on website. 2. No systematic change required under new management company 3. No monitoring needed, policy embedded into website design. 4. N/A 5. 9/24/2025 6. https://premierlivingreno.com/nevada-anti-discrimination-notice/ 7. N/A	09/24/2025

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	adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require 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 or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit 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 from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments:			

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	Inspector Comments: Based on observation and interview, the facility failed to ensure posting of the nondiscrimination policy was on the facility's internet marketing. Findings include: On 09/11/2025 at 11:30 AM, the required nondiscrimination posting was not on the facility's webpage.			
Y 1840 SS= F	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on interview and personnel record review, the facility failed to provide	Y 1840	1. Complete employee training record audit for active employees to identify those missing initial and annual infectious disease training. Employees identified with missing training will be required to complete training prior to next work day. 2. Tickler spreadsheet set up for employee due date tracking, email reminders sent to employees in the month prior to due date. Executive Director to review new hire training checklists for completion within 30 days of hire. Annual training records to be audited by Executive Director or designee within 30 days of anniversary date. 3. Executive Director and Business Office Director to conduct monthly audit of caregiver training records to ensure compliance with initial and annual training requirements 4. Executive Director 5. 1/9/2026 6. Employee Record Audit 7. In audit of employee files, will review additional requirements to ensure compliance. Employee #8 has expired Employee #12 no longer employed	01/09/2026

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	documentation of evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases, for unlicensed caregivers, for 4 of 15 employees (Employee #7, #8, #9,#12). Findings include: Employee #7 Employee #7 was hired by the facility as a Medication Technician with a start date of 04/16/2024. Employee #7's personnel file lacked documented evidence of training for control of infection diseases for unlicensed caregivers. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 01/24/2024. Employee #8's personnel file lacked documented evidence of training for control of infection diseases for unlicensed caregivers. Employee #9 Employee #9 was hired by the facility as a Medication Technician with a start date of 12/07/2023. Employee #9's personnel file lacked documented evidence of training for control of infection diseases for unlicensed caregivers. Employee #12 Employee #12 was hired by the facility as a Medication Technician with a start date of 06/13/2024. Employee #12's personnel file lacked documented evidence of training for control of infection diseases for unlicensed caregivers. On 09/11/2025 at 11:55 AM, the			

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	Administrative Assistant confirmed Employees #7, #8, #9 and #12 had not completed the training for the control of infection diseases for unlicensed caregivers. Severity: 2 Scope: 3			