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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory grading re-survey and complaint investigation, State Licensure survey initiated at your facility on 10/31/23 and completed on 01/03/24. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 38 Residential Facility for Group beds for elderly or disabled persons, Category II residents. The census at the time of the survey was 32. Fifteen resident files were reviewed and eleven employees 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. There were seven complaints investigated at the time of survey. Complaint #NV00069110 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: A resident was not given as needed medications when requested. Allegation #2: A resident was not given snacks at night time when requested. Complaint #NV00070084 with the allegation a resident's furniture was removed from the resident's room and replaced with facility furniture could not be substantiated due to lack of evidence. The investigation into the allegation included: Observations included	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EVA BELTEJAR Title: Owner Date: 04/23/2024

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	a tour of the facility, inspection of resident furniture, including the resident of concern, and the kitchen. Interviews were conducted with the Manager #1/Assistant Administrator, Manager #2 and a Caregiver. Document review included the admission packet, physician determination, ultimate user agreement, Medication Administration Record (MAR), staff shift coverage, menus, and physician orders. CPT #NV00069709 with the the following allegations could not be substantiated for abuse or neglect due to lack of evidence. Allegation #1: A resident was abused. Allegation #2: A resident was not provided feeding assistance. The investigation into the allegations included: Observations of residents and staff interacting in common areas, staff responding to resident call lights, and staff providing set up and feeding assistance to residents in their rooms and the dining room. Interviews were conducted with a the resident of concerns family member, eight residents, two caregivers, and the manager. Clinical record review included the resident of concern's history and physical, diet orders, activities of daily living (ADL) assessment, and physician orders. CPT #NV00069518 with the following allegations could not be substantiated for abuse or neglect due to lack of evidence. Allegation #1: A resident sat in a soiled brief for 11 hours. Allegation #2: A urine specimen was incorrectly collected from a resident. Allegation #3: A resident was not groomed. The investigation into the allegations included: Observations of staff responding to resident call lights and providing care, and residents in their rooms and common areas. Interviews were conducted with eight residents, two caregivers, and the manager. Clinical record review included the resident of concerns history and physical, Activities of Daily Living (ADL) assessments, and physician orders. CPT #NV00069110 with the the following allegations could not be substantiated for abuse or neglect due to lack of evidence. Allegation #1: A resident			

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	was not given as needed medications when requested. Allegation #2: A resident was not given snacks at night time when requested. The investigation into the allegation included: Observations included a tour of the facility, kitchen, and the medication room. Interviews were conducted with the Assistant Administrator and a Caregiver. Clinical record review included the resident of concerns history and physical, ADL assessments, physician orders, physician determination, ultimate user agreement, MAR, and staff shift coverage. Clinical record review included the resident of concerns history and physical, ADL assessments, and physician orders. CPT #NV00069870 with the allegation the facility failed to administer scheduled medications to a resident as ordered by the resident's physician was substantiated (See tags Y0883 and Y0878). The allegation a resident's as needed pain medications were not administered in a timely manner could not be substantiated due to a lack of evidence. The investigation into the allegation included the following: Observations included residents in rooms and in common areas, residents receiving care, and the administration of medications. Clinical record review included resident assessments, progress notes, physician orders, and Medication Administration Records for 15 sampled residents, including the resident of concern. Interviews were conducted with a Caregiver/Medication Technician and two managers. Document review included the Medication Administration Training Certificates for four employees and the facility's Medication Administration/Medication Technician policy. CPT #NV00069989 with the allegation the facility failed to properly administer a medication to resident was substantiated (See tags Y0050, Y0883, and Y0878). The allegation the facility lost a resident's morphine and improperly stored the medication could not be substantiated due to a lack of evidence. The investigation			

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	into the allegation included the following: Observations included residents in rooms and in common areas, residents receiving care, and the administration of medications. Clinical record review included resident assessments, progress notes, physician orders, and Medication Administration Records for 15 sampled residents, including the resident of concern. Interviews were conducted with a Caregiver/Medication Technician and two managers. Document review included the Medication Administration Training Certificates for four employees and the facility's Medication Administration/Medication Technician policy. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, document review, record review, and interview the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision, and failed to ensure a facility Manager did not make decisions regarding resident care without consulting the physician for 1 of 15 sampled residents (Resident #4). Findings include: Please see TAGs Y0072, Y0074, Y0088, Y0102, Y0104, Y0178, Y0255,	0050	1. The facility will immediately ensure that all residents, especially those on Hospice care ,receive their medications as prescribed, without unauthorized alterations. All staff has been retrained with an emphasis to effectively communicate to a doctor and never assume. They will always follow based on authorized, licensed personnel who are deemed able to make those decisions. Instead of acting on patient care assumptions, staff will document and communicate immediately to the proper medical provider. 2. Facility has implemented a mandatory regular meetings for all staff, administrators, and supervisors on the correct administration of medications and the importance of following physician orders precisely, with a special focus on end-of-life care. Update facility policy to reinforce that	03/25/2024

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	Y0278, Y0280, Y0450, Y0520, Y0532, Y0592, Y0876, Y0878, Y0883, Y0895, Y1045, Y1540, Y1810, Y1815, Y1825, and Y1830. Resident #4 Resident #4 was admitted to the facility on 10/06/21, with diagnoses including Alzheimer's disease with early onset, repeated falls, pain, unspecified, essential (primary) hypertension, and muscle weakness. A physician's order dated 12/06/23 documented morphine 15 milligram (mg) instant release (IR) tablets, give 7.5 mg (1/2 tablet) three times per day for pain. Resident #4's MAR dated December 1, 2023 - December 31, 2023 (December 2023), documented the resident was to receive Morphine 7.5 mg (1/2 tablet) IR, three times per day at 8:00 AM, 2:00 PM, and 8:00 PM. The MAR lacked documented evidence morphine 7.5 mg (1/2 tab) IR was administered to Resident #4 at 2:00 PM and 8:00 PM on 12/27/23. The last documented dose of morphine was administered to Resident #4 on 12/28/23 at 8:00 AM. A Hospice Client Coordination Report dated 12/29/23, documented Resident #4 expired on 12/29/23 and the documented time of death was 1:59 AM. On 01/03/24 at 2:08 PM, Manager2 confirmed residents on Hospice should continue to receive palliative care including medications such as morphine through the end of life as ordered by the resident's physician. On 01/03/24 at 3:12 PM, Manager1 confirmed the facility did not notify the hospice agency, including Resident #4's physician the resident's pain medication was being held. Manager1 verbalized the manager knew Resident #4 was not in pain and explained the resident still had residue from the pain medication in the resident's mouth from the previous dose, therefore the medication did not need to be administered. Manager1 acknowledged the manager was not aware the resident had missed more than one dose of pain medication during the time the resident was actively dying. On 01/03/24 at 3:12 PM, Manager1 verbalized		medication technicians, administrators, and supervisors are not to make autonomous decisions regarding medication administration without consulting a physician. 3. Facility administrator, manager 1 or manager 2 to audit MARs regularly and initial to document audit. Will be brought up in all regular meetings to ensure repetitive reminders. All staff has been retrained and disciplinary reminders set if failure to follow guidelines. 4. Facility administrator will ensure plan of correction implemented. 5. Completion date: 3.25.2024 6. All pertinent documents uploaded.	

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	when Resident #4 was no longer able to swallow, morphine 7.5 mg (1/2 tablet) IR, the medication was administered by crushing the medication and placing it between the resident's cheek and gum. Manager1 explained the manager could tell the resident was not in pain because of the managers background as a caregiver and therefore the resident did not need to be administered the scheduled doses of morphine as ordered by the resident's physician. A document titled "Signs of Approaching Death," with a copyright date of 2023, retrieved from the Hospice Foundation of America on 01/22/24, documented, "Often before death, people will lapse into an unconscious or coma-like state and become completely unresponsive. This is a very deep state of unconsciousness in which a person cannot be aroused, will not open their eyes, or will be unable to communicate or respond to touch. Persons in a coma may still hear what is said even when they no longer respond. It should be assumed that even while a person may not have the capacity to speak, they may continue to have the ability to feel pain, or distress, even if they are unable to verbalize those feelings." The facility policy titled "Medication Plan/Medication Technicians," undated, documented Medication Technicians, the Administrator, and supervisors (managers) could not make decisions regarding which medications to give or to hold and were to contact the physician for further instructions. Cross reference with Y0878 and Y0883 Severity: 3 Scope: 2 CPT #NV00069989			
0072 SS= F	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required	0072	1. Employee #10 has been enrolled in a Bureau-approved Medication Management Training course to complete the required hours of training. Ensure completion of this training is prioritized and completed. All managers and staff have been retrained with an emphasis they are not to administer medication until all licenses have been verified. 2. Implemented a new policy requiring all	03/25/2024

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	pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure 1 of 4 sampled employees who administered medications to residents was trained in medication management and had current Medication Management training (Employee #10). The deficient practice had the potential to affect all residents with Ultimate User Agreements. Findings include: Employee #10 Employee #10 was hired at the facility on 10/25/23 as a Caregiver. On 01/03/24 at 9:30 AM, Employee #10 was administering medications to residents. On 01/03/24 at 3:12 PM, a facility Manager1 confirmed the facility lacked documented evidence Employee #10 had completed a Medication Management Training course. On 01/03/24 at 11:07 AM, Employee #10 verbalized the employee was a Medication Technician and was responsible for administering medications to residents. On 01/03/24 at 3:12 PM, the facility was not able to provide documented evidence Employee #10 had completed a Medication Administration Training course. On 01/03/24 at 3:16 PM, Employee #10 confirmed working as a		new hires to be designated to administer medications to complete their Medication Management Training and practical training before starting their role. Developed a checklist for the hiring process that includes verification of completed training and a system for tracking annual training requirements for all medication-related staff. 3. The facility's administrator will be responsible for monthly audits of employee files to ensure compliance with training requirements. This includes verification of initial and ongoing annual training documentation for all staff responsible for medication management. 4. Facility administrator ensure plan of correction implemented. 5. 3.25.2024 6. Employee #10 medication management training has been uploaded. 7. Conducted an audit of all current medication-related staff to ensure compliance with the required training and documentation. This will identify if similar deficiencies exist among other employees. Review and revise related policies and procedures to reinforce the importance of compliance with training requirements across all areas of care, ensuring a consistent approach to staff training and document.	

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	Medication Tech and confirmed the employee was responsible for administering medications to residents. On 01/03/24 at 3:18 PM, Manager2 confirmed Employee #10 was responsible for administering medications to the residents and confirmed the facility did not have documented evidence Employee #10 had completed a Medication Administration course. Manager1 explained Employee #10 did not need a certificate of completion for a Medication Administration Training course because both Manager1 and Manager2 were present and had certificates of completion for a Medication Management Training course. The facility policy titled "Medication Plan/Medication Technicians," undated, documented all staff designated to administer medications must receive proper training prior to assignment. an initial training of 12-hours had to be completed at a Bureau approved medication management class and four hours of practical training had to be completed at the facility. Documentation of the 16 training hours was required to be in the employee's personnel file. An 8 hour training course was required each year and documentation of the annual training was required to be kept in the employee's file. Severity: 2 Scope: 3			
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the	0074	1. Employee #11 has completed an elder abuse prevention training program. They will not work directly with residents until they have successfully completed the training and received a certificate of completion. Management to ensure items are graded and filed correctly. Employee resigned sometime in January 15,2024 and was rehired April 2024. 2. Implemented a mandatory policy that all new hires must complete elder abuse prevention training before starting work with residents. This policy will also include a process for verifying the completion of such training. Introduced a new hire checklist for the manager verification of completed elder abuse prevention training as well as	04/07/2024

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	application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and		ensuring test was graded appropriately. 3. The facility's administrator will be responsible for monthly audits of all new employee files for the first 60 days after hiring to ensure compliance with the elder abuse prevention training requirement. An audit report will be generated and reviewed by management staff. 4. Facility manager will oversee the implementation and monitoring of this corrective action plan to ensure compliance. 5. 4/7/2024 The immediate enrollment and completion of training for Employee #11 will be achieved by [Insert specific date within a month]. The implementation of the new policy and verification process will be in place by [Insert specific date within two months]. 6. Elder abuse training uploaded with Employee file checklist 7. Conducted a comprehensive review of all current employee files to ensure compliance with elder abuse prevention training requirements. Any other deficiencies identified will be corrected immediately, with those employees also being temporarily removed from direct care until training is completed. Regularly review and update training programs and hiring processes to ensure they remain effective and compliant with regulations and best practices.	

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	violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review, document review, and interview,			

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	the facility failed to ensure 1 of 11 sampled employees had initial elder abuse prevention training prior to working with residents (Employee #11). Findings include: The facility's Plan of Correction (POC) dated 11/04/20, documented, "the Administrator will not hire a worker without an elder abuse training completed." The facility's POC dated 12/14/22, documented, "the Day Supervisor was responsible to review and ensure all employee records were complete." The facility's POC dated 06/13/23, documented the change of overseeing records through an outsider reviewer will highlight any lack of records or any missing records in the future. The Administrator is responsible to make this happen. Employee #11 Employee #11 was hired as a Caregiver with a start date of 10/27/23. Employee #11's personnel file documented an elder abuse prevention training test undated which had not been reviewed and scored for a passing grade by management, and lacked documented evidence of a certificate of completion. On 10/31/23 at 11:45 AM, the Assistant Administrator confirmed Employee #11's personnel file lacked documented evidence of completed elder abuse prevention training and the certificate of completion was not in another location. The Assistant Administrator verbalized Employee #11 was working with residents. Severity: 2 Scope: 1			
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review and interview, the facility failed to maintain an accurate staffing schedule, including times when shifts started and	0088	1. Have revised the current staffing schedule to accurately include work hours, types of staff working each shift, and any staffing changes such as sick days or shift swaps. This will be completed immediately for the current and future schedules. Once manager is informed of staffing changes, they will immediately post in all visibility in office of staffing changes for all staff and residents to know. 2. Implement new scheduling software or system that requires input of staff work	03/28/2024

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EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

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	ended, the type of staff working, and any staffing changes. Findings include: On 10/31/23, review of the October 2023 staffing schedule revealed four staff members working day shift, four staff members working swing shift and one staff member working graveyard shift daily. There were no work hours on the schedule to reflect which staff was working when, there was no designation of type of staff working, and no amendments to the schedule for sick days, or other shift changes. On 10/31/23 at 12:12 PM, the Assistant Administrator confirmed the work times and type of staff working was not noted on the schedule nor any changes to the schedule were documented and verbalized if there was a change in staffing, it should be noted on the posted schedule. Severity: 1 Scope: 3		hours (ADP), roles, and allows for real-time updates to reflect any changes. This system will be mandatory for use by all managers responsible for scheduling. Developed and distributed a standard operating procedure (SOP) for scheduling that includes steps for recording and updating the schedule with the required details. Once manager is informed of staffing changes, they will immediately post in all visibility in office of staffing changes for all staff and residents to know. 3. Manager will conduct bi-weekly audits of the staffing schedules for the first three months following the implementation of the new system, then monthly thereafter, to ensure compliance with the new SOP. A monthly report of these audits will be reviewed by the facility's administrator. 4. Facility administrator will be responsible to ensure plan of correction implemented. 5. Completed 3.28.2024. ADP Live 4.15.2024 6. Staff scheduled has been uploaded. Copies of the revised SOP for scheduling. 7. Schedules put out 1 month in advance and shift changes documented appropriately.	
0102 SS= F	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on personnel file review, document review, and interview,	0102	1. TB screenings (QuantiFERON tests) for Employees #5, #7, #9, #10, and #11 have been completed- No positives. Employee #7 was identified during survey in October, and test completed in November, but was misfiled and unable to locate in a timely manner during January survey. All test have been	04/08/2024

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	the facility failed to ensure 1) a tuberculosis (TB) screening was completed for 5 of 11 sampled employees (Employee #5, #7, #9, #10, and #11), and 2) a pre-employment physical examination was completed for 4 of 11 sampled employees (Employee #1, #7, #10, and #11). Findings include: The facility's Plan of Correction (POC) dated 12/14/22, documented, "the Day Supervisor was responsible to review and ensure all employee records were complete." The facility's POC dated 06/13/23, documented future plan of having an outside auditor/reviewer was expected to improve compliance. Administrator was responsible for all. NOTE: Starting immediately all new employees who need TB tests will be asked to obtain a QuantiFERON rather than Skin Test for TB screening. Employee #1 Employee #1 was hired as an Assistant Administrator with a start date of 09/01/23. Employee #1's personnel file documented a pre-employment physical dated 02/03/04, however, the pre-employment physical exam was not completed within six months of Employee #1's hire date. Employee #5 Employee #5 was hired as a Caregiver with a start date of 04/15/23. Employee #5's personnel file documented a positive QuantiFERON TB test dated 06/23/23. Employee #5's personnel file lacked documented evidence of a chest x-ray to determine TB status and a pre-employment physical. Employee #7 Employee #7 was hired as a Caregiver with a start date of 12/19/22. Employee #7's personnel file documented a one step TB test given on 02/13/23 at 2:36 PM and read negative on 02/16/23 at 12:36 PM. Employee #7's personnel file lacked documented evidence of a second step TB test and a completed pre-employment physical. Employee #9 Employee #9 was hired as a Housekeeper with a start date of 11/25/22. Employee #9's personnel file documented a positive QuantiFERON TB test dated 06/23/23. Employee #9's personnel file lacked documented evidence of a chest x-ray to		correctly filed in employee files. Physical examinations completed for Employees #1, #7, #10, and #11. 2. Implemented a revised onboarding process that includes a checklist to ensure TB screenings and pre-employment physicals are completed before the employee starts working. This process will require verification by the management. Established a partnership with a local health service provider to streamline TB screenings and physical examinations for new hires. Utilitize ADP to help with onboarding checklist. 3. The facility administrator will conduct a monthly review of all new hire files before onboarding to ensure TB screening and pre-employment physical requirements. A compliance report will be submitted to the management staff for review. 4. The facility administrator will be responsible for overseeing the immediate scheduling of TB screenings and pre-employment physicals for the affected employees and the implementation of the revised onboarding process. 5.completion date:4/8/2024 6. Supporting Documents have been uploaded. 7. Reviewed all employee files to identify any other individuals who may lack necessary TB screenings	

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	determine TB status and a pre-employment physical. Employee #10 Employee #10 was hired as a Caregiver with a start date of 10/25/23. Employee #10's personnel file lacked documented an two step TB test and a pre-employment physical exam. Employee #11 Employee #11 was hired as a Caregiver with a start date of 10/27/23. Employee #11's personnel file lacked documented an two step TB test and a pre-employment physical exam. On 10/31/23 at 11;53 AM, the Assistant Administrator confirmed Employee #5, #7, #9, #10, and #11 lacked completed tuberculosis TB testing and Employee #1, #7, #10, and #11 lacked pre-employment physical examinations. The Assistant Administrator verbalized the documents were not in another location. This is a repeat deficiency from the grading re-survey on 04/13/23. Severity: 2 Scope: 3		or pre-employment physical examinations. Schedule screenings and examinations as needed. Evaluate other compliance areas related to employee health and safety to ensure all regulatory requirements are being met. Implement corrective actions as necessary based on findings.	
0104 SS= F	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on personnel file review, document review and interview, the facility failed to ensure 4 of 11 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.124 (Employee #1, #4, #7 and #9). Findings include: The facility's Plan of Correction (POC) dated 12/14/22, documented, "the Day Supervisor was responsible to review and ensure employee records were complete." The facility's POC dated 06/13/23, documented the Administrator was reviewing all background requirements and working with the employees to comply and the Administrator was responsible for this. Employee #1 Employee #1 was hired as the Assistant	0104	1. Immediate Action, Employees #1, #7, and #9 have completed all missing background check components, including fingerprint submission to the Central Repository for Nevada Records of Criminal History, Criminal History Statements, and obtaining Nevada Automated Background Check System (NABS) clearance letters. Documentation: All necessary documentation will be placed in each employee's personnel file to demonstrate compliance. Employee number #4 no longer employed. 2. Policy Revision: We will revise our hiring policies to include a mandatory checklist that aligns with NRS 449.124 requirements. This checklist will be used for all new hires and existing employee audits. Training: All staff responsible for hiring and personnel file management, including the Day Supervisor and Administrator, will receive training on the revised policies and the importance of compliance with background check requirements. 3. Onboarding Audits: The Administrator will audit of onboarding employee files to	04/08/2024

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	Administrator with a start date of 09/01/23. Employee #1's personnel file lacked documented evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 10/31/23 at 11:45 AM, the Assistant Administrator confirmed Employee #1's personnel file lacked documented evidence of fingerprints being submitted, a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #1 was scheduled to work in October 2023. Employee #4 Employee #4 was hired as a Caregiver with a start date of 05/01/22. Employee #4's personnel file lacked documented evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 10/31/23 at 11:45 AM, the Assistant Administrator confirmed Employee #4's personnel file lacked documented evidence of fingerprints being submitted, a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #4 was scheduled to work in October 2023. Employee #7 Employee #7 was hired as a Caregiver with a start date of 12/19/22. Employee #7's personnel file lacked documented evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 10/31/23 at 11:55 AM, the Assistant Administrator confirmed Employee #7's personnel file lacked documented evidence of fingerprints being submitted, a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #7 was scheduled to work in October 2023. Employee #9 Employee #4		ensure ongoing compliance with NRS 449.124. ADP will be used as an electronic onboarding source. 4. The Facility Administrator is designated as the responsible party for the oversight and implementation of this POC. 5. Completion Date: 4/8/2024_____ 6. Documentation: All nabs documents uploaded 7. Facility-Wide Review: In addition to correcting the specific findings, a facility-wide review of all employee files will be conducted to identify and correct any similar deficiencies. Preventive Measures: The same systematic changes and monitoring strategies outlined above will be applied universally to prevent recurrence in any area of our operations.	

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	was hired as a Housekeeper with a start date of 11/25/22. Employee #9's personnel file documented evidence of fingerprints taken on 06/22/23. Employee #9's personnel file lacked documented evidence of a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 10/31/23 at 11:59 AM, the Assistant Administrator confirmed Employee #9's personnel file lacked documented evidence of a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #9 was scheduled to work in October 2023. A NABS report dated 10/30/23 at 9:35 AM, documented lack of evidence of a background check for Employee #1, #4, #7 and #9. This is a repeat deficiency from the grading re-survey of 04/13/23. Severity: 2 Scope: 3			
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure environment in the courtyards were free from debris and hazards, the flooring in the facility was in good repair, the heating/air conditioning return vents and filters were free of dust and debris, the patio access door was in good repair, bathrooms were in clean and working order, and maintenance was performed with the potential to affect 32 of 32 resident census. Findings include: Courtyards On 10/31/23 at 9:14 AM, the west courtyard had the following items on the patio: - bed frame - one shovel and one rake - one five gallon bucket full of paint - an unlocked storage shed - a 32 ounce bottle of cleaner labeled pine On 10/31/23 at 9:18 AM, the south courtyard had the following items on the patio: - an excess amount of garbage in garbage bags	0178	1. Immediate Clean-Up: Removed all debris, hazardous materials, and unsanitary items from courtyards, repair or replace damaged flooring, ensure all vents and filters are cleaned and replaced, fix the patio access door, and thoroughly clean and sanitize all bathrooms. Documentation: Photos and maintenance logs will be kept as evidence of corrective actions. 2. Scheduled Maintenance and Inspection: Implement a daily inspection and maintenance schedule to ensure the environment is free from debris and hazards, the facility is in good repair, and cleanliness is maintained. Walkthrough done by facility manager daily. Training: Conduct mandatory training sessions for all maintenance and cleaning staff on safety and cleanliness standards,	04/01/2024

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	(approximately 15 bags of trash) and approximately 13 empty cardboard boxes. - an unlocked storage shed with chemicals. On 10/31/23 at 9:24 AM, the Assistant Administrator confirmed residents came out to walk or smoke on the patio daily. The Supervisor confirmed all of the items on the patio were a safety and health hazard to all of the residents. On 10/31/23 at 9:28 AM, the Supervisor confirmed all eight heating/air conditioning return vents and filters had a heavy accumulation of lint and dust and verbalized not knowing the last time the vents were cleaned and the air filters changed. The filters were not dated when they were changed. On 10/31/23 at 9:14 AM, the Supervisor confirmed portions of the flooring in the B Hallway had an area where the flooring was buckling and verbalized they created a hazard for residents. On 10/31/23 at 9:24 AM, the Assistant Administrator confirmed the patio door was in a state of disrepair and need to be removed and replaced. On 10/31/23 at 10:50 AM, the common area bathroom had the following: - Soiled adult breifs located in the bathroom trash can. - Feces smeared on the wall behind the bathroom trash can. On 10/31/23 at 9:24 AM, the Assistant Administrator confirmed the bathroom was not cleaned and sanitary for residents within the facility. The Assistant Administrator stated that the cleaning staff should always be trained on cleaning the facility properly, as it could be dangerous to the health and wellbeing of residents within the facility. This is a repeat deficiency from the grading re-survey on 04/13/23. Severity: 2 Scope: 3		including the secure storage of chemicals and the importance of regular cleaning and maintenance routines. 3. Audit System: Introduce a monthly audit system, overseen by the Facility Administrator, to check for compliance with the cleaning and maintenance schedules, and to ensure that environmental safety and cleanliness standards are met. Reporting Mechanism: Develop a clear reporting mechanism for staff to report hazards, damage, or cleanliness issues, with immediate action required for any issues reported. Maintenance personel has been kept on retainer to help facility outside obstacles and repairs of facility. 4. Implementation: The Facility Administrator is tasked with the oversight and implementation of this Plan of Correction, ensuring that all actions are completed as scheduled. 5. Completion Date:04/01/2024 6. All pertinent documentation has been uploaded. 7. Facility-Wide Review: Conduct a facility-wide review to identify any other areas potentially affected by similar deficiencies. This review will extend to all resident areas, common areas, and service areas within the facility. Preventive Measures: Apply the same systematic changes and monitoring strategies universally across the	

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			facility to prevent the occurrence of similar deficiencies in the future.	
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 10/31/23, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. The high temperature dishmachine was not sanitizing at the time of inspection. The final rinse cycle was not reaching proper temperature. Further observation noted the interior water dispensing manifolds were damaged. This was a repeat deficiency from the inspection conducted on 4/13/23. 2. Rodent dropping were observed behind the kitchen stove. In addition, the area behind the stove was heavily soiled with food and debris. This was a repeat deficiency from the inspection conducted on 4/13/23. Severity: 2 Scope: 3	0255	1. Immediate Replacement has been scheduled to ensure that the high-temperature dish machine is replaced so that the final rinse cycle reaches the proper temperature. Areas in kitchen that are not immediately seen such behind the stove has been deep cleaned. as The dishwasher has been immediately placed out of commission and dishes washed and sanitized. Pest Control: A licensed pest control service will be engaged to address and eliminate any rodent issues in the kitchen area. All kitchen and cleaning staff retrained to maintain sanitary conditions. New replacement dishwasher ordered already. 2.Regular Maintenance Schedule: Implement a monthly maintenance schedule for all kitchen equipment, ensuring they meet health and safety standards. Cleaning Protocol: Introduce a daily deep cleaning protocol for the kitchen, focusing on areas prone to food debris accumulation. Pest Management Program: Establish an ongoing contract with a pest control service for regular inspections and treatments. Retained maintenance personnel to help monitor device problems. 3. Maintenance and Cleaning Logs: Maintain detailed logs of all maintenance and cleaning activities. These logs will be reviewed monthly by the Facility Administrator. Pest Control Records: Keep records of all pest control visits and treatments, with quarterly reviews to ensure effectiveness. 4. Facility Administrator Oversight: The Facility Administrator is responsible for ensuring the implementation and adherence to this Plan of Correction. 5. Completion Date: 4/9/2024_____ 6. Documentation: Receipt of new	05/03/2024

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			dishwasher has been uploaded. 7. Comprehensive Facility Review: Conduct a comprehensive review of all facility areas to identify potential for similar deficiencies. Priority will be given to high-risk areas such as other utility rooms and storage areas. Expansion of Protocols: Apply the established maintenance, cleaning, and pest control protocols facility-wide to mitigate any identified risks.	

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0272 SS= C	Service of Food - Menus - NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days.	0272	1. Immediate Menu Documentation has been posted 30 days in advance. All menus are written, planned 3 weeks in advance, properly dated, and posted in a conspicuous place accessible to residents. Additionally, these menus will be filed and maintained for a period of 90 days as required. 2. Menu Planning and Posting Procedure: Facility manager conducts monthly audit review and creates the menu at least 3 weeks in advance. This procedure will also include guidelines for making and documenting any changes to the menus. Staff Training: Conduct training sessions for dietary staff and any involved personnel on the new menu planning and posting procedures to ensure understanding and compliance. 3. Weekly Audits: Facility Manager, under the oversight of the Facility Administrator, will conduct weekly audits to verify that menus are appropriately planned, posted, and filed according to the established procedure as well as being followed by kitchen staff. Random audits with residents will help ensure correct feedback system. 4. The Facility Administrator is designated as the responsible party for overseeing the implementation of this Plan of Correction and ensuring compliance with NAC 449.2175. 5. Completion Date:04/03/2024_____ 6. Menu uploaded 7. Facility-Wide Compliance Review: Conduct a facility-wide review to identify other areas where documentation practices may not meet regulatory requirements. Application of Corrective Framework: Apply the framework developed for correcting the menu documentation deficiency to any other areas identified during the review, ensuring comprehensive compliance across all operational aspects.	04/03/2024

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0278 SS= F	Dietary Consult - More Than 10 Residents - NAC 449.2175 Service of food 9. A residential facility with more than 10 residents shall employ or otherwise obtain the services of a person to serve as a consultant for the planning and serving of meals who: (a) Is a licensed dietitian; or (b) Is a graduate from an accredited college with a major in food and nutrition and has 2 years of supervisory experience in a medical facility or facility for the dependent or has participated in a course of training for a supervisor of the service of food. Inspector Comments: Based on interview and observation, the facility failed to employ a Registered Dietician or other qualified personnel for a facility with greater than 10 beds with the potential to affect 32 of 32 resident census. Findings include: On 10/31/23 at 2:29 PM, the Assistant Administrator (AA) explained the facility did not have a Registered Dietician (RD) or other qualified personnel on staff. The AA was unable to determine the exact amount of time the facility was without an RD. The AA produced an email forwarded from the Administration from the previous Dietitian dated July 2022, documenting the Dietitian was willing to help the Administrator find another Dietitian for the facility. Severity: 2 Scope: 3	0278	1. Contracted a new Registered Dietitian whose license is current and in good standing, to provide quarterly consultations, employee training, nutritional compliance advice, and observations of food preparation and service of meals. Dietician contracted since 10/6/2023, but unable to procure documents in timely manner for survey. 2. Annual review of the dietitian's contract and verification of license renewal to ensure continuous compliance. This process will include setting reminders for contract renewal and license verification 60 days before expiration. Dietitian Consultation Schedule: Established a set schedule for quarterly consultations with the Registered Dietitian, including specific dates and objectives for each visit, to ensure consistency and compliance. Training and Compliance Documentation: Developed a template for documenting the dietitian's visits, including topics covered during employee training, advice given, observations made, and follow-up actions taken. 3. Conduct quarterly reviews to ensure that consultations with the Registered Dietitian are taking place as scheduled and that documentation is properly maintained. These reviews will also assess the implementation of the dietitian's recommendations. Annual Audit: Perform an annual audit to evaluate the effectiveness of the dietitian's input on nutritional compliance, food preparation, and meal service quality. 4. The Facility Administrator is tasked with the overall responsibility for ensuring the implementation and adherence to this plan of correction. 5. Completed 1.20.24_____ 6. All pertinent documents have been uploaded. 7. Conduct a comprehensive review of all nutritional services offered by the facility to identify any other areas lacking compliance or where improvements can be made. This	01/20/2024

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			review will extend to meal planning, resident satisfaction with meals, and special dietary accommodations.	
0280 SS= F	Dietary Consultant & Services - 10. The person providing services pursuant to subsection 9 shall provide those services not less than once each calendar quarter. The administrator of the facility shall keep a written record of the consultations on file at the facility. The consultations must include: (a) The development and review of weekly menus; (b) Training for the employees who work in the kitchen; (c) Advice regarding compliance with the nutritional program of the facility; and (d) Any observations of the person providing the services regarding the preparation and service of meals in the facility to ensure that the facility is in compliance with the nutritional program of the facility. Inspector Comments: Based on interview and document review, the facility failed to ensure a Registered Dietitian provided quarterly consultations including employee training, nutritional compliance advice, and observations of food preparation and service of meals with the potential to affect 32 of 32 resident census. Findings include: On 10/31/23 at 2:29 PM, the Manager indicated the facility had contracted with a Registered Dietitian but provided no documented evidence of the contract service. A report dated 02/17/22, documented a report from a Dietitian and the posted Dietitian's license was expired on 06/24/23. There was no documented evidence of quarterly consultations with the Registered Dietitian after 02/17/22 or any reports from 2023. Severity: 2 Scope: 3	0280	1. Contracted a new Registered Dietitian whose license is current and in good standing, to provide quarterly consultations, employee training, nutritional compliance advice, and observations of food preparation and service of meals. 2. Annual review of the dietitian’s contract and verification of license renewal to ensure continuous compliance. This process will include setting reminders for contract renewal and license verification 60 days before expiration. Dietitian Consultation Schedule: Established a set schedule for quarterly consultations with the Registered Dietitian, including specific dates and objectives for each visit, to ensure consistency and compliance. Training and Compliance Documentation: Developed a template for documenting the dietitian’s visits, including topics covered during employee training, advice given, observations made, and follow-up actions taken. 3. Conduct quarterly reviews to ensure that consultations with the Registered Dietitian are taking place as scheduled and that documentation is properly maintained. These reviews will also assess the implementation of the dietitian's recommendations. Annual Audit: Perform an annual audit to evaluate the effectiveness of the dietitian's input on nutritional compliance, food preparation, and meal service quality. 4. The Facility Administrator is tasked with the overall responsibility for ensuring the implementation and adherence to this plan of correction. 5.Completed on 1.30.24 _____ 6. All pertinent documents have been uploaded. 7. Conduct a comprehensive review of all	01/30/2024

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			nutritional services offered by the facility to identify any other areas lacking compliance or where improvements can be made. This review will extend to meal planning, resident satisfaction with meals, and special dietary accommodations.	

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0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 1 of 9 sampled employees maintained training and certification to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #5). Findings include: The facility's Plan of Correction dated 12/14/22, documented the Day Supervisor was responsible to review and ensure all employee records were complete. The facility's POC dated 06/12/23, documented the facility would obtain employee training and certificate for first aid and CPR and the Administrator was responsible for auditing employee files. Employee #5 Employee #5 was hired as a Caregiver with a start date of 04/15/23. Employee #5's personnel file lacked documented evidence of current CPR and first aid certification. On 10/31/23 at 12:00 PM, the Assistant Administrator confirmed Employee #5 lacked CPR and first aid training within 30 days of their hire date and verbalized the employee had been scheduled to work with residents since their hire dates. Severity: 2 Scope: 1	0450	1. Immediate Certification: Employee #5 was enrolled in the next available CPR and First Aid training course; Documentation of completion will be filed in Employee #5's personnel file. 2. Training Compliance Procedure: Implement a comprehensive procedure to ensure all employees have current CPR and First Aid certification as part of their initial orientation and ongoing employment requirements. Employee File Audit: Develop a semi-annual audit process for reviewing all employee files to ensure compliance with CPR and First Aid certification requirements. Retained a consistent trainer to provide group trainings for all staff. 3. Audit Schedule: The Facility Administrator, in coordination with the Day Supervisor, will conduct and document semi-annual audits of employee files to ensure ongoing compliance with training certifications. Corrective Action Log: Maintain a log of employee files and findings and corrective actions taken, reviewed quarterly by the Facility Administrator. All employees with lapse in training will be removed from floor. 4. Facility Administrator Implementation: The Facility Administrator is tasked with ensuring the Plan of Correction is implemented effectively and in a timely manner. 5. Completion Date:_1/3/2024_____ 6. Documentation: all pertinent documentation uploaded. 7. Comprehensive Employee File Review: A review of all current employee files will be conducted to identify any other employees lacking the required certifications. Any identified deficiencies will be corrected using the established corrective action process. Preventative Measures for New Hires: Incorporate the training compliance procedure into the hiring process to prevent future occurrences of similar deficiencies.	01/03/2024

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0520 SS= F	Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 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; (e) Permission for the resident to rest in his or her room at any time; (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 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 a person-centered service plan was developed to address the facility's treatment of residents for 14 of 14 residents reviewed for service plans (Resident #1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #13, #14, and	0520	1. 1. Immediate action has been taken to review and develop personalized service plans for the residents identified in the Statement of Deficiencies. As of now, service plans have been successfully created and implemented for Residents #1, #2, #5, #7, #8, #12, #14, and #15.It's important to note that Residents #3, #4, #6, #10, and #13 have sadly passed away, and Resident #11 has been transferred to a different facility. For these residents, we will ensure that our records accurately reflect their statuses ,and that any relevant documentation is properly archived in accordance with regulatory requirements and facility policies. Family, residents and caregivers will collaborate to ensure that each plan is tailored to the individual needs, preferences, and treatment requirements of the residents. WI 2.mplemented a standardized process for the development, review, and updating of person-centered service plans for all residents upon admission and at regular intervals, as well as whenever there are significant changes in a resident's condition. Training sessions will beheld for all staff on the importance of these plans and on how to create and update them effectively. 3. 3 Regular audits will be conducted to ensure compliance with the creation, implementation, and updating of person-centered service plans. The frequency of these audits will initially be monthly for the first six months, followed by quarterly reviews to ensure ongoing compliance. 1. The facility administrator is responsible for overseeing the implementation of the Plan of Correction and ensuring that all staff	04/23/2024

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	#15). Findings include: The following residents' records lacked documented evidence of a person-centered service plan to address the treatment needs of the residents by the facility's caregiver staff: - Resident #1 was admitted to the facility on 09/13/22, with diagnoses including pyelonephritis, hypertension, and gastroesophageal reflux disease. - Resident #2 was admitted to the facility on 08/01/23, with diagnoses including acquired hypothyroidism, dysphagia, prediabetes and major depressive disorder. - Resident #3 was admitted to the facility on 10/02/20, with diagnoses including diabetes, hypertension, and gait. - Resident #4 was admitted to the facility on 10/06/21, with diagnoses including Alzheimer's disease with early onset, repeated falls, pain, unspecified, essential (primary) hypertension, and muscle weakness. - Resident #5 was admitted to the facility on 03/15/23, with a diagnosis of Parkinson's disease. - Resident #6 was admitted to the facility on 12/31/20, with diagnoses including kidney failure, hyperlipidemia, and prostate cancer. - Resident #7 was admitted to the facility on 02/20/23, with diagnoses including schizoaffective disorder, and suicidal ideation. - Resident #8 was admitted to the facility on 06/04/21, with diagnoses including Parkinson's disease, and Barret's esophagus. - Resident #10 was admitted to the facility on 04/04/14, with diagnoses including dementia, schizoaffective disorder, and protein calorie malnutrition. - Resident #11 was admitted to the facility on 08/16/23, with diagnoses including vascular dementia and chronic artery disease. - Resident #12 was admitted to the facility on 02/03/23, with a diagnosis of Parkinson's disease. - Resident #13 was admitted to the facility on 11/17/23, with diagnoses including hypothyroidism, carotid artery disease, chronic pain, chronic heart failure, and type II diabetes mellitus. - Resident #14 was admitted to the facility on 06/12/17, with diagnoses including		are trained and compliant with the new processes. 2. **Completion date 4.9.2024.** 3. **Supporting Documents** have been uploaded. 7. 7.To ensure that this deficiency does not exist in other areas or potentially affect other residents, a facility-wide assessment will be conducted to identify any similar issues. This will include a review of service plans for all residents to ensure they are current and meet the person-centered criteria. Necessary corrections will be made following the outlined plan.	

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	rheumatoid arthritis and major depressive disorder. - Resident #15 was admitted to the facility on 03/15/22, with a diagnosis of schizoaffective disorder, bipolar type. On 01/03/24 at 2:28 PM, Manager #1 confirmed the facility had not created person-center service plans for the residents currently residing in the facility affecting the entire facility census. Severity: 2 Scope: 3			
0532 SS= C	Activities for Residents - NAC 449.260 Activities for residents. (NRS 449.0302) 1. The caregivers employed by a residential facility shall: (g) Post, in a common area of the facility, a calendar of activities for each month that notifies residents of the major activities that will occur in the facility. The calendar must be: (1) Prepared at least 1 month in advance; and (2) Kept on file at the facility for not less than 6 months after it expires. Inspector Comments: Based on observation, document review, and interview, the facility failed to post a current activities calendar for 32 of 32 residents and failed to provide an activities calendar for the subsequent month. Findings include: On 10/31/23 at 8:47 AM, during the tour of the facility, the September 2023 activities calendar was posted in a common area. The October 2023 activities calendar was not posted. On 10/31/23 from 8:30 AM to 3:30 PM, there were no activities conducted. Three residents were observed either in the common area, in their room, in bed, watching television or sleeping. On 10/31/23 at 2:33 PM, the Assistant Administrator confirmed the October 2023 activities calendar was not posted in the facility and verbalized the November 2023 activities calendar was not available and needed to be created since November started tomorrow. Severity: 1 Scope: 3	0532	1. Activities have been posted with the current month's and posted activities calendar in all common areas and distribute copies to all residents. All previous activities calendars have been filed. 2. Calendar Development Procedure: Establish a procedure requiring the activities calendar for the upcoming month to be developed, reviewed by the Facility Administrator, and posted in common areas by the 25th of each current month. Resident Involvement: Implement monthly meetings with residents to gather input on desired activities, ensuring engagement and relevance. Monthly checklist of monthly task such as audit checks, menus, activities etc. has been created. 3. Monthly Review: The Facility Administrator will review the activities calendar development and posting process monthly to ensure compliance with the new procedure. 4. Facility Administrator Implementation: The Facility Administrator is responsible for the oversight and timely implementation of this Plan of Correction. 5. Completion Date:___4.1.2024_____ 6. Documentation: activity calendar has been uploaded.	04/01/2024
0590 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and	0590	1.Investigated all specific incidents detailed	01/05/2024

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	response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility;		in the Statement of Deficiencies to identify and address any instances of abuse, neglect, or exploitation. This will involved detailed interviews with affected residents, staff members, and any other relevant parties, alongside a review of facility surveillance and reports. Assistant administrator has been scheduled alongside manager on site to help monitor incidents. 2. Revised the facility's policies to strengthen the protection of residents, clearly outlining the steps for reporting grievances, and ensuring strict confidentiality and protection from retaliation. Staff Training: Implement comprehensive training for all existing and new staff focusing on resident rights, recognizing, and preventing abuse, and the importance of promptly addressing grievances and complaints. Established a more accessible and straightforward process for residents to report grievances, including anonymous options. 3. Manager and assistant administrator to regularly review grievances and the outcomes of any investigations. Conduct quarterly audits to ensure the continuous implementation of the corrective measures and identify any areas for improvement. 4. The Facility Administrator is tasked with the oversight of this plan's implementation, ensuring all staff are informed and compliant with the new policies and procedures. 5. 01/05/2024 6. All supporting documents uploaded. 7. Conduct a facility-wide risk assessment to identify other areas potentially affected by similar deficiencies.	

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0592 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity; Inspector Comments: Based on observation and interview, the facility failed to ensure resident dignity was maintained when the caregiver stood and fed the resident at the dining room table and did not ask the resident if the resident was done eating before taking the resident's plate for 1 of 8 residents observed eating (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on 02/03/23, with a diagnosis of Parkinson's disease. On 10/31/23 at 12:00 PM, Resident #12 was served lunch. The resident had a built-up spoon and fork used for assisted feeding on the plate. On 10/31/23 at 12:11 PM, Resident #12 began eating with their hands. The Caregiver approached the resident and put the built-up utensils in the resident's hands and showed the resident how to use the built-up fork utensil. On 10/31/23 at 12:14 PM, Resident #12 attempted to use the spoon, however the resident was not successful. The food fell off of the spoon before the resident could take a bite. On 10/31/23 at 12:17 PM, Resident #12 attempted to use the fork, however the resident was not successful, and the food fell off the fork before the resident could take a bite. On 10/31/23 at 12:20 PM, the Caregiver approached Resident #12, stood at the resident's side, and began feeding the resident. On 10/31/23 at 12:25 PM, the Caregiver left the resident to eat alone at the table to clear plates from other tables. On 10/31/23 at 12:28 PM, Resident #12 attempted to use the built-up utensils,	0592	1. Immediate Retraining: All caregivers have undergone immediate retraining on maintaining resident dignity, with a focus on feeding practices. This includes sitting next to the resident during feeding, ensuring communication and consent before removing plates, and adapting to the resident's daily independence levels. 2. Feeding Assistance Protocol: Addressed during an employee meeting a in depth reminder for feeding assistance that emphasizes dignity ,communication, and resident autonomy. This meeting detailed procedures for sitting with residents during meals, verbal communication before plate removal, and personalized feeding assistance based on daily assessments of the resident's abilities. This training topic will be a consistent reminder in meetings. Staff Performance Reviews: Incorporate assessment of adherence to the feeding assistance protocol into regular staff performance reviews. 3. Regular Observations: The Facility Administrator, incoordination with the Manager, will conduct weekly observations of mealtimes to ensure compliance with the new feeding assistance protocol. Findings will be documented and reviewed in monthly staff meetings. Resident Feedback: Implement a monthly feedback session with residents to gather insights on their dining experience, focusing on aspects of dignity and staff interaction during meals. 4. Facility Administrator Implementation: The Facility Administrator is responsible for overseeing the implementation of this Plan of Correction, ensuring all staff are trained, protocols are followed, and monitoring mechanisms are in place.	01/05/2024

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	however they were not successful, and the resident resorted to eating with their fingers. On 10/31/23 at 12:33 PM, the Caregiver returned to Resident #12 and took the resident's plate. The Caregiver did not speak to the resident or ask the resident if the resident was finished eating prior to taking the resident's plate. On 10/31/23 at 3:00 PM, the Caregiver verbalized Resident #12 required assistance to eat. The resident's level of independence changed depending on the day. The resident was provided with built up utensils, the staff would give the resident education on how to use the utensils and allow the resident to attempt to feed themselves. The Caregiver explained the resident needed one to one feeding assistance today. The Caregiver verbalized one to one feeding assistance included sitting next to the resident and feeding the resident each bite of food, while giving the resident enough time to chew and swallow before offering another bite. The Caregiver confirmed the Caregiver did not sit next to the resident and did not ask the resident if the resident was finished eating when the Caregiver took the resident's plate away. On 10/31/23 at 3:15 PM, Resident #12 verbalized the resident needed assistance eating to include staff feeding the resident. The resident explained the staff usually stand up next to the resident when assisting the resident with feeding and the resident felt embarrassed by the action. The resident verbalized the resident felt the Caregivers were in a hurry and they rarely asked if the resident was done eating before they took the resident's plate away. On 10/31/23 at 3:40 PM, the Manager verbalized caregivers should sit next to the residents when providing one to one feeding assistance and the caregivers should ask the resident if they were finished eating before taking their plate. Severity: 2 Scope: 1		5. Completion Date:01/05/2024 6. Documentation: Supporting Documents: Training records ,the new feeding assistance protocol, staff performance review criteria, observation logs, and resident feedback summaries will be maintained as evidence of compliance.	
0620 SS= F	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS	0620	1. Immediately revised the facility’s admission agreement to explicitly include	04/01/2024

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(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
	449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis.		prohibitions against admitting residents who are bedfast, require restraint, need confinement in locked quarters, or need skilled nursing or medical supervision on a 24-hour basis. This revision will align with the stipulations of NAC 449.2702 and R043 -22. Please see section 19 on admission agreement. 2. Conduct training sessions for all admissions staff and administrative personnel to ensure understanding and compliance with the revised admission policies. Training will emphasize the importance of accurately assessing prospective residents' care needs during the admissions process. Implemented a standardized review process for all admission applications to ensure compliance with the revised policy, including a mandatory assessment by a qualified healthcare professional. 3. Schedule monthly audits of admissions records for the first week following the implementation of the revised policy. Manager to audit all files and admittance before acceptance into facility. 4. The facility administrator will oversee the implementation of the plan, ensuring that all staff members are informed about the policy changes and trained appropriately. The administrator will also be responsible for the ongoing monitoring of the plan’s effectiveness and compliance. 5. Completion date:04/01/2024 6. New admission policy has been uploaded. 7. Conduct a comprehensive review of all facility policies to identify any other areas where practices may not align with current regulations or standards of care such as auditing all resident files.	

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		A. BUILDING _____ B. WING _____	**01/03/2024**

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EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 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 clinical record review and interview, the Administrator failed to ensure an ultimate user agreement was completed for 3 of 15 sampled residents (Residents #3, #6, and #15). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/02/20, with diagnoses including diabetes, hypertension, and gait. Resident #3's clinical record lacked documented evidence of an Ultimate User Agreement. Resident #3's Medication Administration Record (MAR) dated October 2023, documented facility staff had administered all resident medications to the resident. Resident #6 Resident #6 was admitted to the facility on 12/31/20, with diagnoses including kidney failure, hyperlipidemia, and prostate cancer. Resident #6's clinical record lacked documented evidence of an Ultimate User Agreement. Resident #6's MAR dated October 2023, documented facility staff had administered all resident medications to the resident. On 10/31/23 at 10:45 AM, the Assistant Administrator confirmed Resident #3 and Resident #6 did not have an Ultimate User Agreement completed and verbalized an Ultimate User Agreement needed to be completed to	0876	1. Ultimate User Agreements are completed for Residents #3, #6, and #15. These agreements will clarify whether these residents can self-administer their medications or if facility staff need to manage the medications on their behalf. Resident #3 and #6 has since passed away and resident #15 ultimate user agreement uploaded. Documentation: The completed Ultimate User Agreements will be placed in each resident's clinical record and a copy provided to the resident or their representative. 2. Addressed the facility's admission procedures to include the completion of an Ultimate User Agreement as part of the initial intake process for all new residents. Staff Training: Conduct training sessions for all staff to emphasize the importance of the Ultimate User Agreement in medication administration and management, ensuring compliance with updated admission procedures. Ultimate user agreement has been included in the resident checklist. 3. Regular Audits: The Facility Administrator, in conjunction with the management staff, will conduct monthly audits of resident files to verify the presence of Ultimate User Agreements and compliance with medication management policies. 4. Facility Administrator Implementation: The Facility Administrator is tasked with the responsibility for the implementation and ongoing oversight of this Plan of Correction. 5. Completion Date:04/09/2024 6. Documentation: user agreements have been uploaded. 7. Facility-Wide File Review: Conduct a	04/09/2024

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	determine if the resident was able to take their own medication or if the facility needed to manage the medications. Resident #15 Resident #15 was admitted to the facility on 03/15/22, with a diagnosis of schizoaffective disorder, bipolar type. Resident #15's record lacked documented evidence of a signed Ultimate User Agreement by the resident or the resident's representative. On 01/03/24 at 2:18 PM, Manager #2 confirmed Resident #15 lacked a signed Ultimate User Agreement and verbalized the facility was administering Resident #15's medications. Severity: 2 Scope: 1		comprehensive review of all resident files to identify and correct any similar deficiencies regarding medication management documentation. Expanded Training and Audits: Extend the updated admission procedures, staff training, and audit processes to cover all aspects o fresident care documentation, ensuring facility-wide compliance with regulatory requirements.	
0878 SS= E	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	0878	1. Immediate Review and Correction: For Resident #2,contacted the prescribing physician immediately to clarify medication orders and ensure medication is administered as prescribed moving forward. For Resident #14 and Resident #4, conduct a detailed review of their Medication Administration Records (MAR) to identify and rectify the missed medications and ensure no further doses are missed. For Resident #4, obtain a physician's order for crushing medications if required due to the resident's condition. All staff have been retrained with a thorough emphasis on facility's medication administration policies to include strict guidelines for administering ,documenting, and reviewing medications. Staff understands they are to never assume guidelines or medication choices and always consult an document with assigned medical staff. 2. All staff have been retrained with a thorough emphasis on facility's medication administration policies to include strict guidelines for administering, documenting, and reviewing medications. This included protocols for when medications can be crushed and require documented physician's orders for any alterations to medication administration forms. Staff Training: Conduct mandatory meetings for all Medication Technicians (MTs) and	04/01/2024

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	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 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, record review, document review, and interview the facility failed to ensure 1) medications were on-site to administer as prescribed for 1 of 15 residents with medications reviewed (Resident #2), 2) medications were administered per physician's order for 3 of 15 residents with medications reviewed (Resident #2, #14, and #4), and 3) a medication was not crushed without an order to crush the medication for 1 of 15 residents with medications reviewed (Resident #4). Findings include: Resident #2 Resident #2 was admitted to the facility on 08/01/23, with diagnoses including acquired hypothyroidism, dysphagia, prediabetes and major depressive disorder. A physician's order dated 09/27/23, documented hydrocodone 10 mg/acetaminophen 325 milligrams (mg), take one tablet every eight hours as needed for 30 days. Resident #2's Medication Administration Record (MAR) dated		relevant staff on the updated medication administration policies, with a focus on the importance of adhering to physicians' orders and accurately documenting medication administration. 3. Monitoring Corrective Actions: Monthly MAR Audits: The facility administrator will oversee monthly audits of MARs, conducted by a designated manager, to ensure all medications are administered as prescribed and properly documented. Reporting and Review Mechanism: Establish a reporting mechanism for audit findings, with corrective actions taken for any discrepancies noted. Review these findings quarterly with all medication administration staff to reinforce policies and procedures. 4. Responsibility: The Facility Administrator is responsible for the implementation, oversight, and regular review of this plan of correction to ensure compliance and address any deficiencies promptly. 5. Completion Date:_04/01/2024 6. Documentation: All pertinent documentation has been uploaded. 7. Comprehensive Review of Medication Management Practices: Conduct a facility-wide review of all medication management practices to identify any similar deficiencies or areas for improvement. This review will extend to all aspects of medication handling, from procurement to administration.	

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	October 1, 2023 - October 31, 2023 (October 2023), documented the resident had been administered the medication one or more times each day on October 1 through October 31. On 10/31/23 at 12:48 PM, the Assistant Administrator confirmed Resident #2 had been given the hydrocodone/acetaminophen for more than 30 days and there was still medication left in the bubble pack. The Assistant Administrator verbalized the facility did not understand the medication was to be given for only a 30 day period and would need to contact the physician for further orders. Resident #14 Resident #14 was admitted to the facility on 06/12/17, with diagnoses including dementia without behavioral disturbance, overactive bladder, and hyperlipidemia. A physician's order dated 11/07/23, documented Atorvastatin calcium 20 mg tablet, give one tablet by mouth at bedtime for hyperlipidemia. A physician's order dated 09/14/23, documented risperidone 0.5 mg tablet, give one tablet by mouth two times daily for dementia without behavioral disturbance. A physician's order dated 09/14/23, documented Tamsulosin HCl (hydrochloride) 0.4 mg capsule, give one capsule by mouth at bedtime for overactive bladder. Resident #14's MAR dated November 1, 2023 - November 30, 2023 (November 2023), documented medications were not administered as follows: -Atorvastatin 20 mg tablet, one tablet was to be given at 8:00 PM on 11/12/23 and was not administered. -Risperidone 0.5 mg tablet, was to be given at 5:00 PM on 11/12/23 and was not administered. -Tamsulosin 0.4 mg capsule was to be given at 8:00 PM on 11/12/23 and was not administered. A Medication Technician (MT) initialed the administration box for 11/12/23 for each of the medications and drew a bubble around each of the boxes to indicate the medication was not given. The MT did document the reason the medications were not given on the MAR, including the back of the MAR. On 01/03/24			

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	at 12:26 PM, an MT verbalized when a medication was not administered, the MT was to draw a circle/bubble around the administration time box on the resident's MAR and initial inside the box. The reason the medication was not administered was to be documented on the back of the MAR. On 01/03/24 at 12:51 PM, facility Manager1 was not able to explain what was being documented when an MT drew a bubble around an administration time box on a resident's MAR and initialed inside the box. On 01/03/24 at 12:58 PM, facility Manager2 verbalized the Managers (Manager1 and Manager2) were responsible for overseeing the MTs. Manager2 explained when a medication was not administered to a resident, the expectation was the MT would draw a bubble around the administration time on the resident's MAR and initial inside the box. The reason the medication was not administered was to be documented on the back of the resident's MAR. Manager2 confirmed the reason Atorvastatin, risperidone, and Tamsulosin were not administered to Resident #14 should have been documented on the back of the resident's MAR and was not documented by the MT. Manager2 verbalized the Manager had taken an approved Medication Administration course and recalled being taught when a medication was not administered, to draw a circle around the administration time box and write the reason the medication was not given on the back of the resident's MAR. Resident #4 Resident #4 was admitted to the facility on 10/06/21, with diagnoses including Alzheimer's disease with early onset, repeated falls, pain, unspecified, essential (primary) hypertension, and muscle weakness. A physician's order dated 12/06/23 documented morphine 15 mg instant release (IR) tablets, give 7.5 mg (1/2 tablet) three times per day for pain. Resident #4's clinical record lacked documented evidence of an order to crush the resident's medications. Resident #4's			

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	MAR dated December 1, 2023 - December 31, 2023 (December 2023), documented the resident was to receive Morphine 7.5 mg (1/2 tablet) IR, three times per day at 8:00 AM, 2:00 PM, and 8:00 PM. The MAR lacked documented evidence morphine 7.5 mg (1/2 tab) IR was administered to Resident #4 at 2:00 PM and 8:00 PM on 12/27/23. The last documented dose of morphine was administered to Resident #4 on 12/28/23 at 8:00 AM. A Hospice Client Coordination Report dated 12/29/23, documented Resident #4 expired on 12/29/23 and the documented time of death was 1:59 AM. On 01/03/24 at 2:03 PM, Manager2 confirmed Resident #4's MAR lacked documented evidence the resident was administered scheduled Morphine 7.5 mg (1/2 tablet) IR on 12/28/23, at 2:00 PM and 8:00 PM, as ordered by the resident's physician. The Manager was not sure why the medication was not administered and confirmed the medication was a scheduled medication and should have been administered. On 01/03/24 at 2:08 PM, Manager2 confirmed residents on Hospice should continue to receive palliative care including medications such as morphine through the end of life as ordered by the resident's physician. Severity 2 Scope 2 Cross Reference with Y0050 and Y0883 CPT #NV00069989 CPT #NV00069870			
0883 SS= D	Medication - Resident Refusal - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 7. If a resident refuses, or otherwise misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to ensure the physician was notified of missed medications for 2 of 15 sampled residents	0883	1. Immediate Notification: For Residents #14 and #4, the facility has immediately notified the respective physicians about the missed medications and documented the communication in the residents' clinical records. The facility will follow the physicians' directives for missed doses and monitor the residents for any adverse effects due to missed medications. Conducted mandatory training for all Medication Technicians, emphasizing the importance of timely communication with physicians and	04/01/2024

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	(Resident #14 and #4). Findings include: Resident #14 Resident #14 was admitted to the facility on 06/12/17, with diagnoses including dementia without behavioral disturbance, overactive bladder, and hyperlipidemia. A physician's order dated 11/07/23, documented Atorvastatin calcium 20 milligram (mg) tablet, give one tablet by mouth at bedtime for hyperlipidemia. A physician's order dated 09/14/23, documented risperidone 0.5 mg tablet, give one tablet by mouth two times daily for dementia without behavioral disturbance. A physician's order dated 09/14/23, documented Tamsulosin HCl (hydrochloride) 0.4 mg capsule, give one capsule by mouth at bedtime for overactive bladder. Resident #14's MAR dated November 1, 2023 - November 30, 2023 (November 2023), documented medications were not administered as follows: -Atorvastatin 20 mg tablet, one tablet was to be given at 8:00 PM on 11/12/23 and was not administered. -Risperidone 0.5 mg tablet, was to be given at 5:00 PM on 11/12/23 and was not administered. -Tamsulosin 0.4 mg capsule was to be given at 8:00 PM on 11/12/23 and was not administered. A Medication Technician (MT) initialed the administration box for 11/12/23 for each of the medications and drew a bubble around each of the boxes to indicate the medication was not given. The MT did not document the reason the medications were not given on the MAR, including the back of the MAR. On 01/03/24 at 12:26 PM, an MT verbalized when a medication was not administered the MT was to draw a circle/bubble around the administration time box on the resident's MAR and initial inside the box. The reason the medication was not administered was to be documented on the back of the MAR. On 01/03/24 at 12:58 PM, Manager2 confirmed when medications could not be administered to a resident, the resident's physician was to be notified within 12 hours. Manager2 confirmed Resident #14's clinical record lacked		accurate documentation for any medication irregularities. 2. Policy Update: Revised the facility's medication administration policy to include a clear procedure for notifying physicians and/or hospice care providers immediately of any missed medication doses. This policy will detail steps for documentation in both the MAR and clinical record. Staff Training: Conducted mandatory training for all Medication Technicians, emphasizing the importance of timely communication with physicians and accurate documentation for any medication irregularities. Documentation Tools: demonstrated section in the MAR for documenting the reason medications were not administered and any follow-up actions taken, including notifications to physicians. 3. Audit and Oversight: The Facility Administrator will oversee monthly audits of MARs and clinical records to ensure compliance with the medication administration policy and proper documentation of physician notifications for missed medications. Reporting System: Implemented a reporting system for MTs and staff to log incidents of missed medications and subsequent notifications to physicians, to be reviewed monthly by the Facility Administrator and nursing manager. 4. The Facility Administrator is responsible for ensuring the implementation and adherence to this Plan of Correction, overseeing staff training, monthly audits, and the establishment of the reporting system. 5. Completion Date: ___4.1.2024_____ 6. Documentation: All documentation	

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	documented evidence of the reason the medications were not given. Resident #4 Resident #4 was admitted to the facility on 10/06/21, with diagnoses including Alzheimer's disease with early onset, repeated falls, pain, unspecified, essential (primary) hypertension, and muscle weakness. A physician's order dated 12/06/23 documented morphine 15 mg instant release (IR) tablets, give 7.5 mg (1/2 tablet) three times per day for pain. Resident #4's MAR dated December 1, 2023 - December 31, 2023 (December 2023), documented the resident was to receive Morphine 7.5 mg (1/2 tablet) IR, three times per day at 8:00 AM, 2:00 PM, and 8:00 PM. The MAR lacked documented evidence morphine 7.5 mg (1/2 tab) IR was administered to Resident #4 at 2:00 PM and 8:00 PM on 12/27/23. The last documented dose of morphine was administered to Resident #4 on 12/28/23 at 8:00 AM. On 01/03/24 at 2:03 PM, Manager2 confirmed Resident #4's MAR lacked documented evidence the resident was administered scheduled Morphine 7.5 mg (1/2 tablet) IR on 12/28/23, at 2:00 PM and 8:00 PM, as ordered by the resident's physician. The Manager was not sure why the medication was not administered and confirmed the medication was a scheduled medication and should have been administered. On 01/03/24 at 1:57 PM, Manager2 confirmed the hospice agency and physician were not informed Resident #4's scheduled morphine was not being administered as ordered and should have been notified within 12 hours. The facility policy titled "Medication Plan/Medication Technicians," undated, documented Medication Technicians, the Administrator, and supervisors (managers) could not make decisions regarding which medications to give or to hold and were to contact the physician for further instructions. Scope 2 Severity 1 Cross reference with Y0878 and Y0050 CPT #NV00069989 CPT #NV00069870		has been uploaded. 7. Facility-Wide Review: Conduct a facility-wide review of medication administration and documentation practices to identify any similar issues with other residents or medications. Expansion of Corrective Measures: Apply the updated policies, training, and monitoring procedures to all areas identified during the review to ensure comprehensive compliance and prevent recurrence of similar deficiencies.	

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

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0895 SS= D	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. Inspector Comments: Based on observation, record review, document review, and interview, the facility failed to ensure 1) an as needed medication had symptoms being treated documented on the medication administration record (MAR) for 2 of 8 residents with medications reviewed (Resident #2, and #4), and 2) the resident MAR was accurate and contained all medications being administered for 1 of 8 residents with medications reviewed (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 08/01/23 with diagnoses including acquired hypothyroidism, dysphagia, prediabetes and major depressive disorder. Resident #2's MAR dated October 1, 2023 -	0895	1. Immediate Update of MAR: For Resident #2 and Resident #4, the facility will immediately update the MAR to include the specific symptoms for which as-needed medications (Hydrocodone/Acetaminophen for Resident #2 and Lorazepam for Resident #4) are to be administered. For Resident #2, the MAR will also be updated to accurately reflect the administration of Centrum women multivitamin as per the physician's order. Review and Verification: The facility has conducted a thorough review of the medication orders and MAR for Residents #2 and #4 to ensure all medications are correctly documented and administered according to physician orders. All staff retrained in meds practices and procedures. 2. Staff Training: Conduct mandatory training for all medication administration staff, including Medication Technicians and nursing staff, on the updated MAR policy, emphasizing the importance of accurately documenting symptoms for as-needed medications and ensuring the MAR is comprehensive and up to date. Medication Review Process: Instilled medication review process to verify the accuracy of MARs against physician orders, focusing on the inclusion of symptoms for as-needed	04/01/2024

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	October 31, 2023 (October 2023), documented Hydrocodone/Acetaminophen 10-325 milligrams (mg), take one tablet by mouth every eight hours as needed. A physician's order dated 09/27/23, documented Hydrocodone 10 mg/Acetaminophen 325 milligrams (mg), take one tablet by mouth every eight hours as needed for 30 days. On 10/31/23 at 12:28 PM, the Assistant Administrator confirmed the resident's MAR lacked the symptoms for taking the Hydrocodone/Acetaminophen and verbalized there should have been a symptom for giving the medication. Resident #2's medications in the medication cart included Centrum women multivitamin and was labeled with the resident's name and ordering physician's name and instructions to take one table daily. A physician order dated 08/01/23, documented Centrum silver ultra women's, take one tablet once a day for 90 days. Resident #2's October 2023 MAR lacked documented evidence of the multivitamin. On 10/31/23 at 12:40 PM, the Assistant Administrator confirmed Resident #2 was being administered the Centrum and Resident #2's October 2023 MAR lacked the documented evidence of the administration of the medications. Resident #4 Resident #4 was admitted to the facility on 10/06/21, with a diagnoses including dementia and depression On 10/31/23 at 11:10AM, during a medication review with a Med Tech, the following medication was available in the medication cart for Resident #4: - Lorazepam 0.50 milligram (mg) oral tab, give one tablet by mouth every four hours as needed for anxiety. A Physician's Order for Resident #4, dated 07/24/23, documented the following order: - Lorazepam 0.50 milligram (mg) oral tab, give one tablet by mouth every four hours as needed for anxiety. The October 2023 MAR for Resident #4 did include the lorazepam, however, no symptoms were listed on the MAR for reason given. On		medications and the completeness of the MAR. 3. Monthly Audits: The Facility Administrator will oversee monthly audits of MARs for all residents to ensure compliance with the updated MAR policy and accuracy of medication documentation. Ensure monthly medication management team meetings to keep all policies and procedures in fore front of staff practices. 4. The Facility Administrator is tasked with responsibility for the oversight and implementation of this Plan of Correction, including staff training, monthly MAR audits, and ensuring policy updates are communicated and adhered to by all staff. 5. Completion Date:__04/01/2024_____ 6. Documentation: All pertinent documentation has been uploaed. 7. Facility-Wide MAR Review: Conduct a facility-wide review of MARs for all residents to identify any similar documentation issues or inaccuracies. Extension of Corrective Measures: Apply the updated policies, training, and audit procedures to all areas identified during	

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	10/31/23 at 11:23 AM, the Med Tech confirmed the MAR was not up to date for Resident #4. The Med Tech verbalized the MAR should be accurate and include the most current medication orders. Severity: 2 Scope: 1			
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 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.	0920	1. Immediate Remediation: Reviewed and reorganized the current medication storage areas to ensure all medications, including over the counter and externally applied medications, are stored in accordance with NAC449.2748. This includes securing medications in a locked, cool, and dry area, and ensuring medications requiring refrigeration are stored in a locked refrigerator or a locked box within the refrigerator. Staff has been retrained in medication storage protocols and procedures. 2. The facility's medication storage area has been moved to a different locked room that is solely for medication management and storage procedures to maintain a more organized system. The storage room contains places suitable for all types of medications and medical equipment to prevent misuse or unauthorized access. Staff Training: Conducted comprehensive training for all caregivers and relevant staff on the updated medication storage policies, focusing on the importance of secure medication storage and the potential risks associated with improper storage. All new medication and audited and logged for storage accuracy and explained to resident if necessary. 3. Monthly Storage Audits: The Facility Administrator, in conjunction with the nursing manager, will conduct monthly audits of medication storage areas using the newly developed audit tool. These audits will ensure compliance with the updated storage policies and NAC 449.2748 requirements.	02/01/2024

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			4. The Facility Administrator is responsible for overseeing the implementation and adherence to this Plan of Correction. This includes ensuring that staff training is conducted, monthly audits are completed, and any identified issues are promptly addressed. 5. Completion Date:02/01/2024 6. Documentation: All pertinent information documented. 7. Comprehensive Review of Medication Management Practices: Conduct a facility-wide review of all medication management practices to identify any similar deficiencies or areas for improvement, extending beyond storage to include documentation, administration, and disposal. Application of Corrective Measures: Apply the corrective measures developed for medication storage to other identified areas, ensuring facility-wide compliance with medication management standards.	
0923 SS= E	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.	0923	1. Conducted a thorough review of all current medication storage areas and resident medications to ensure compliance with NAC 449.2748. All staff retrained in medication management to not alter any meds. This will involve verifying that all medications, including over-the-counter medications and dietary supplements, are: Plainly labeled with contents, the name of the resident for whom it is prescribed, and the name of the prescribing physician. Kept in their original container until administered.	01/10/2024

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			2. Retrained all staff on medication management policies to reinforce the requirements for medication labeling and storage as per NAC 449.2748. This will include detailed procedures for receiving, storing, and documenting medications. Training sessions for all staff on the updated medication management policies, focusing on the importance of medication safety, labeling, and storage practices. 3. Conduct monthly audits of medication storage and labeling practices to ensure ongoing compliance with NAC 449.2748. These audits will be documented and reviewed by the management. Feedback Mechanism: Establish a feedback loop for staff to report any challenges or deviations in medication management practices, ensuring timely corrective actions can be taken. 4. The Facility Administrator is responsible for the overall implementation of this plan of correction, ensuring that all actions are completed in a timely and effective manner. 5. 01/10/2024 6. All pertinent documents uploaded. 7. Perform a facility-wide risk assessment to identify any other areas potentially affected by similar deficiencies. This will include reviewing other policy areas related to resident care and safety	

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1010 SS= F	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915.	1010	1. Completed the process to obtain the necessary endorsement on the facility's license that authorizes it to operate as a residential facility for persons with mental illnesses. This includes submitting the application to the Division along with all required documentation and evidence of compliance with NAC 449.191 or 449.1915 and ahs been posted. Note: Requirements for mental Health Endorsement have been submitted through M.Smothers These include the mental Health Training and the Fire Clearance for the endorsement The latest input from M,Smothers is that the documents will be forwarded to the surveyor To complete the documentation, we are uploading the training records and fire clearance certificate 2. Assistant administrator to audit all licenses and stay on top of requirements for obtaining and maintaining the necessary endorsements for providing care to residents with mental illnesses. 3. Conduct quarterly audits to review compliance with state regulations concerning the care of residents with mental illnesses. Audit findings will be reported to the facility's administrator and used to make continuous improvements. 4.The facility administrator is responsible for overseeing the implementation of this corrective plan, including submission of the endorsement application, policy revisions, staff training, and compliance monitoring. 5. Completion Date:04/08/2024 6. Copies of the application for endorsement have been uploaded.	04/08/2024

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1045 SS= C	Placard - Display - NAC 449.27704 Placard: Issuance and display; failure to comply. (NRS 449.0302) 2. The administrator shall, within 24 hours after receipt of the placard, display or cause the placard to be displayed conspicuously in a public area of the residential facility. Inspector Comments: Based on observation and interview, the facility failed to conspicuously display the D letter grade from the previous grading re-survey State Licensure survey. Findings include: On 10/31/23 at 8:32 AM, the D letter grade from the 04/13/23 grading re-survey State Licensure survey was posted behind an opaque folder sitting in a folder holder affixed to the wall and the grade placard was not clearly visible to the public. On 10/31/23 at 9:34 AM, the Assistant Administrator Director confirmed the D grade placard was not clearly visible to the public. Severity: 1 Scope: 3	1045	1. Relocated the D letter grade placard to a prominent, unobstructed location within the facility that is easily visible to the public, as per the regulatory requirements. (in front of office when first entering facility. 2. Posting and displaying state licensure survey grades will be displayed immediately after receiving grade. 3. Regular Compliance Checks of the facility ensure the continued visibility of the licensure survey 4. The Facility Administrator is tasked with the overall responsibility for the implementation of this plan of correction. 5. 01/03/2024 6. Picture of grade visibility has been uploaded. 7. Facility-Wide Review: Conduct a facility-wide review to identify any other compliance issues related to the visibility of important information to the public or staff. This review will include checking for other regulatory or informational postings that may not be adequately displayed.	01/03/2024
1540 SS= E	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	1540	1. Completed approved cultural competency training for Employee #2 and Employee #4. Ensured that documentation of completed training is filed in their personnel files and easily accessible for review. 2. Revised the existing training policy to include a clear requirement for cultural competency training for all employees within 30 days of their hire date, along with procedures for documentation and filing of training certificates. Utilize ADP for onboarding procedures and training requirements. 3. Monthly file Audits: Implement monthly audits of personnel files to ensure compliance with the training policy, focusing on timely completion and documentation of cultural competency training. Feedback and	04/09/2024

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	(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 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		Reporting Mechanism: Establish a feedback mechanism for employees to report any issues with accessing or completing required training. The facility manager will review feedback and take corrective action as needed. 4. The Facility Administrator bears the overall responsibility for the implementation and monitoring of this plan of correction. 5. 04/09/2024 6. Cultural competency certificates have been uploaded. 7. Conduct a facility-wide review of all training requirements and compliance statuses to identify any other areas where training documentation is lacking or training has not been completed as required.	

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	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 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			

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	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 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,			

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	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 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			

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		A. BUILDING _____ B. WING _____	**01/03/2024**

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EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

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	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 file review and interview, the facility failed to ensure employees received cultural competency training within 30 days of their date of hire for 2 of 8 sampled employees requiring cultural competency training (Employee #2 and #4). Findings include: The facility's Plan of Correction dated 12/14/22, documented, "all employees would receive cultural competency training from an approved trainer by December 31, 2022." The facility's POC dated 06/12/23, documented a cultural competency training for all staff members will be conducted. The Administrator was responsible to complete. On 10/31/23, a review of personnel files revealed the following employees lacked documented evidence of cultural competency training: - Employee #2 was hired as the Office Manager with a start date on 01/01/05. - Employee #4 was hired as a Caregiver with a start date of 05/01/22. On 10/31/23 at 11:55 AM, the Assistant Administrator confirmed Employee #2 and #4 did not have the documented evidence for an approved cultural competency training course in their personnel file and the certificate was not in another location. Severity: 2 Scope: 2			
1810 SS= F	Infection Control Program - Infection Control Program LCB File No. R048-22 Sec. 5 1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors;	1810	1.Facility staff members have undergone 15 hours of infectious control training. One manager established as primary and another as secondary to ensure a designee for an infections control program. 2. The facility administrator will monitor Nathan’s bulletins every week to ensure to stay on top of all necessary training procedures as well as the state website. The facility administrator will audit all employee files on a monthly basis to ensure	04/09/2024

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	Inspector Comments: Based on document review and interview, the facility failed to develop a comprehensive infection control program and corresponding policies to prevent and control infections within the facility with the potential to affect 32 of 32 residents. Findings include: On 10/31/23, the facility lacked a comprehensive infection control program with infection control policies in place to ensure the safety needs of residents, staff, and visitors. The facility's infection control program lacked: - Designation of a person to be responsible for coordinating the infection control program for the facility. - Policies and procedures for the control of infectious diseases that are based on current nationally recognized, evidence-based guidelines for the prevention and control of infectious diseases (such as from CDC). - Policies and procedures that reflect the scope and complexity of the services the facility provides. - A strategy for addressing an outbreak of an infectious disease and the effects of such an outbreak at the facility, including, without limitation, staffing shortages, new admissions and readmissions, visitation and protecting residents, patients or clients from the spread of the infectious disease. On 10/31/23 at 12:21 PM, the Manager confirmed the facility had not designated the primary and secondary staff responsible for the facility's infection control in a policy and was not able to produce any documentation of an infection control program addressing the current guidelines for infection control specifically for the facility. Severity: 2 Scope: 3		all proper training and documentation filed and completed. Will also monitor continuing education to stay on top of no lapses in training. All staff will undergo 15 hours of IC training to ensure a replacement of first and secondary in case of a designee leaving. Primary and secondary contact posted in visible area for all residents and staff to contact if necessary. 3.The monthly audits will ensure all training completed and filed. All facility staff to undergo training in case of a primary or secondary designee has left facility employment. 4.Facility administrator will ensure plan of correction implemented. 5.Corrective action completed on 04/09/204 6.IC training has certificate has been uploaded. 7.All employees to undergo IC training to ensure here is always a primary and secondary designee to be always responsible for infection control at all times.	
1815 SS= F	Emergency Preparedness Plan - Emergency Preparedness Plan LCB File No. R048-22 Sec. 5. 1. A facility for the dependent shall: (c) Develop and carry out a comprehensive plan for emergency preparedness. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address	1815	1. Facility has contracted an outside agency, "Assisted Living Education" to help the facility make an updated, comprehensive emergency preparedness plan that includes protocols for internal and external potential local or area disasters, emerging infectious diseases, and clearly	01/04/2024

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	internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on interview and document review, the facility failed to develop a comprehensive emergency preparedness plan with the potential to affect 32 of 32 residents. Findings include: The facility's written emergency preparedness (EP) plan at the time of the grading re-survey documented protocols for fire, earthquakes and loss of power only. The EP plan did not include other internal or external potential local or area disasters or emerging infectious diseases and did not address the responsibilities of staff during an emergency. On 10/31/23 at 12:21 PM, the Manager confirmed the facility did not have a comprehensive written emergency preparedness plan. Severity: 2 Scope: 3		defines the responsibilities of staff during an emergency. This plan will be developed in accordance with local, state, and federal guidelines. Deadline for this is within 30 days. The safety binder will be available at time of survey. Binder placed in a more conspicuous area for easy access. Training for all staff regarding plan and evacuation plan posted in all appropriate areas. 2. Ensure the new emergency preparedness plan includes specific protocols for a range of emergencies, including but not limited to natural disasters (floods, tornadoes, extreme weather), technological incidents (cyber-attacks, power grid failures),and health emergencies (pandemics, local disease outbreaks). Staff Training: Implement regular (at least annual) training sessions for all staff members on their specific roles and responsibilities outlined in the emergency preparedness plan. Include drills and simulation exercises for different emergency scenarios. Policy Update: Update facility policies to require annual reviews and updates of the emergency preparedness plan to incorporate new risks, learnings from drills, and changes in staff roles and responsibilities. 3. Regular Drills and Audits: Conduct regular emergency drills to test the effectiveness of the emergency preparedness plan. Follow each drill with an audit to identify areas for improvement. 4. The Facility Administrator is tasked with the overall responsibility for ensuring the comprehensive emergency preparedness plan is developed, implemented, and maintained according to the plan of correction. 5. 01/04/2024 6. Supporting Documents have been uploaded.	

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

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			7. Facility-Wide Risk Assessment: Conduct a thorough risk assessment to identify other areas of operation that lack comprehensive planning or preparedness, particularly in areas related to resident safety and operational continuity	

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1825 SS= F	I C Program Responsible Person and Designee - IC Program Responsible Person and Designee LCB File No. R048-22 Sec. 5 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. Inspector Comments: Based on interview and record review, the facility failed to ensure a primary and secondary person responsible for the facility's infection control program were identified with the potential to affect 32 of 32 residents. Findings include: On 10/31/23 at 12:21 PM, the Manager verbalized the facility had not designated a primary and secondary person responsible for the facility's infection control program. Severity: 2 Scope: 3	1825	1.Facility staff members have undergone 15 hours of infectious control training. One manager established as primary and another as secondary to ensure a designee for an infections control program. 2. The facility administrator will monitor Nathan's bulletins every week to ensure to stay on top of all necessary training procedures as well as the state website. The facility administrator will audit all employee files on a monthly basis to ensure all proper training and documentation filed and completed. Will also monitor continuing education to stay on top of no lapses in training. All staff will undergo 15 hours of IC training to ensure a replacement of first and secondary in case of a designee leaving. Primary and secondary contact posted in visible area for all residents and staff to contact if necessary. 3.The monthly audits will ensure all training completed and filed. All facility staff to undergo training in case of a primary or secondary designee has left facility employment. 4.Facility administrator will ensure plan of correction implemented. 5.Corrective action completed on 04/09/2024 6.IC training has certificate has been uploaded. 7.All employees to undergo IC training to ensure there is always a primary and secondary designee to be always responsible for infection control at all times.	04/09/2024

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1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 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. Inspector Comments: Based on personnel file review, document review, and interview, the facility lacked a primary and secondary infection control person with the required infection control training with the potential to affect 32 of 32 residents. Findings include: On 10/31/23 at 12:21 PM, the Manager confirmed the required infection control and prevention training had not been completed by any employee working in the facility. Severity: 2 Scope: 3	1830	1.Facility staff members have undergone 15 hours of infectious control training. One manager established as primary and another as secondary to ensure a designee for an infections control program. 2. The facility administrator will monitor Nathan's bulletins every week to ensure to stay on top of all necessary training procedures as well as the state website. The facility administrator will audit all employee files on a monthly basis to ensure all proper training and documentation filed and completed. Will also monitor continuing education to stay on top of no lapses in training. All staff will undergo 15 hours of IC training to ensure a replacement of first and secondary in case of a designee leaving. Primary and secondary contact posted in visible area for all residents and staff to contact if necessary. 3.The monthly audits will ensure all training completed and filed. All facility staff to undergo training in case of a primary or secondary designee has left facility employment. 4.Facility administrator will ensure plan of correction implemented. 5.Corrective action completed on 04/09/2024. 6.IC training has certificate has been uploaded. 7.All employees to undergo IC training to ensure there is always a primary and secondary designee to be always responsible forinfection control at all times.	04/09/2024