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 _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE RENO	**3105 PLUMAS STREET, RENO, NEVADA ,89509**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey and complaint investigation conducted at your facility on 09/21/23. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 56 Residential Facility for Group beds, with assisted living services for elderly or disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 33. Ten resident files were reviewed and twelve employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. Two complaints were investigated. Complaint #NV00069250 and #NV00069332 with the following allegations were substantiated (See tags Y0088, Y0590, Y0878, and Y0966). Allegation #1 - The facility did not have enough staff at all times. Allegation #2 - The facility did not have a Medication Technician to administer medications during a weekend shift and residents did not receive morning medications until the afternoon. The following allegations could not be substantiated due to a lack of evidence. Allegation #3 - The facility asked a Hospice	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARJOLIJN KIRBY Title: ADMINISTRATOR Date: 01/26/2024

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	Nurse to pass medications to all of the residents. Allegation #4 - A resident fell while outside and no one could find a staff member to help them. Allegation #5 - The handles on the door going from the dining room to the courtyard were broken creating a fire safety hazard. Allegation #6 - Rooms were not being cleaned and laundry was piling up in the resident rooms. Allegation #7 - The "manager" was not qualified. Investigation into the allegations included: Observation of cleanliness in resident rooms, shower rooms, dining room, activity room, lounges, the facility grounds, exits including door handles, and resident - staff interactions. Interviews were conducted with three residents, a Caregiver, a Medication Technician, two Registered Nurses (hospice), the Director of Maintenance, the Wellness Director, and the Executive Director. Record review included face sheets with diagnoses, physician orders, and MARs for 14 residents. Hospice records were reviewed for two residents. Document review included the following: - List of residents discharged from the facility during the previous six months - Daily Census reports and list of active residents for the previous three months - Staffing Schedules for the previous six months - Staffing policy - Medication Administration policy - Abuse, Neglect, and Exploitation 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:			

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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, clinical record review, document review, and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAG Y0074, Y0088, Y0100, Y0102, Y0104, Y0174, Y0178, Y0250, Y0252, Y0272, Y0450, Y0590, Y0859, Y0878, Y0895, Y0936, Y0938, Y0966, Y0994, Y0999, Y1001, Y1036, Y0137, Y1540, Y1825, and Y1830. Severity: 2 Scope: 3	0050	Current acting Administrator will provide oversight and direction related to the regulations of Nevada	12/01/2023
0074 SS= F	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 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	0074	Elder Abuse training has been completed for Employee 1, 6, 11, and 12.Annual and initial abuse training was provided on 11/10/23 with remaining employees completed by 12/1/23 per Nevada regulations including mandated reporting. Facility will meet the annual reporting requirements on-going. Documentation of certification of completed elder abuse training will be placed in each employee file on-going . This will be completed by the Business Office Coordinator and Executive Director	12/01/2023

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	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 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			

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	abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 7 of 12 sampled employees received initial elder abuse training prior to beginning work at the facility and annually, thereafter (Employee #1, #3, #6, #7, #10,			

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	#11, and #12). Findings include: On 09/21/23 at 9:54 AM, the Business Office Director was provided with the Personnel Check List to complete for 12 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 05/10/23. Employee #1's personnel file lacked an elder abuse training certificate. Employee #3 Employee #3 was hired by the facility as Resident Care Coordinator with a start date of 09/18/23. Employee #3's personnel file contained an elder abuse training certificate dated 09/19/23. Employee #6 Employee #6 was hired by the facility as Caregiver with a start date of 05/15/23. Employee #6's personnel file lacked an elder abuse training certificate. Employee #7 Employee #7 was hired by the facility as Program Assistant with a start date of 05/01/23. Employee #7's personnel file contained an elder abuse training certificate dated 05/02/23. Employee #10 Employee #10 was hired by the facility as Caregiver with a start date of 06/22/23. Employee #10's personnel file contained an elder abuse training certificate dated 06/27/23. Employee #11 Employee #11 lacked a personnel file kept at the facility. Employee # 12 Employee #12 lacked a personnel file kept at the facility. On 09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			

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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 Administrator failed to maintain a monthly written staff schedule, including schedule changes, for at least six months. Findings include: On 09/21/23 at 1:08 PM, the facility's staffing schedules for March - September 2023, did not indicate staffing changes including when staff called in sick and personal time off. On 09/21/23 at 3:25 PM, the Executive Director confirmed a staff schedule sheet including all staff members, the dates each staff member worked, sick calls and personal time off was not kept by the facility. Severity: 1 Scope: 3 Complaint #NV00069250 and #NV00069332	0088	Staffing schedules will display the necessary 6:1 during waking hours during waking hours staffing needed to provide care to residents. All staffing schedules will be kept and documented the changes to the schedule to show any exceptions including PTO, call-offs, new hires and terminations on-going. 1. A written staffing schedule has been created. Any changes will be posted on the schedule. The schedule will be maintained for six months in the Business Office. Will be maintained by the Business Office Coordinator and Executive Director	12/01/2023

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0100 SS= D	Personnel File - 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: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee; (e) Evidence that the references supplied by the employee were checked by the residential facility. Inspector Comments: Based on observation and interview, the facility lacked personnel files for 2 of 12 sampled employees (Employee #11 and #12). Findings included: Employee #11 Employee #11 was employed as Health and Wellness Director at a sister facility. Employee #11 lacked a personnel file and was performing Health and Wellness duties at this facility. Employee #12 Employee #12 was employed as Maintenance Director at a sister facility. Employee #12 lacked a personnel file and was performing Maintenance duties at this facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employees #11 and #12 worked at the facility and did not have personnel files maintained in the facility. Severity: 2 Scope: 1	0100	Personnel files were assembled for Employees 11 and 12.All current and new employee files are secured and available for inspection the business office at the facility currently and on-going. The Executive Director and/or designee will review the employee list and personnel files monthly for the next six months to confirm that there is a personnel file available for each employee.	12/01/2023
0102 SS= E	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 record review, document review, and interview, the facility failed to ensure employees met the requirements concerning tuberculosis (TB)	0102	TB tests have been completed for employees 4, 6, 7, 11, and 12. All employee files will contain current new hire and annual TB tests, signs and symptoms screenings and on-going. During the pre-hire process, the Business Office Coordinator will ensure all new hires have completed the required physical and TB test prior to beginning. There will be a file tracker to document and maintain	12/01/2023

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	testing and pre-employment physical for 5 of 12 sampled employees (Employee #4, #6, #7, #11, and #12). Findings include: On 09/21/23 at 9:54 AM, the Business Office Director was provided with the Personnel Check List to complete for 12 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Manager provided the completed form with the following information: Employee #4 Employee #4 was hired at the facility as Medication Technician with a start date of 04/28/22. Employee #4's personnel file contained a TB QuantiFERON test dated 04/07/22; however, the personnel file lacked documentation evidence of a TB QuantiFERON test performed in 2023. Employee #6 Employee #6 was hired at the facility as Caregiver with a start date of 05/15/23. Employee #6's personnel file contained a TB QuantiFERON test dated 09/09/22; however, the personnel file lacked documented evidence of a TB QuantiFERON test performed by 09/09/23. Employee #7 Employee #7 was hired at the facility as Programs Assistant with a start date of 05/01/23. Employee #7's personnel file lacked documented evidence of an initial tb test. Employee #11 Employee #11 was employed as Health and Wellness Director at a sister facility. Employee #11 lacked a personnel file with documented evidence of TB testing and pre-employment physical and was performing Health and Wellness duties at this facility. Employee #12 Employee #12 was employed as Maintenance Director at a sister facility. Employee #12 lacked a personnel file with documented evidence of TB testing and pre-employment physical and was performing Maintenance duties at this facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employees #11 and #12 worked at the facility and did not have personnel files maintained in the facility. On 09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated		all employee files. The Business Office Coordinator and Executive Director will be responsible for implementing and maintaining compliance.	

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	09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2			
0104 SS= D	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 record review and interview, the facility failed to ensure 2 of 12 sampled employees met background check requirements (Employee #11 and #12). Findings include: Employee #11 Employee #11 was employed as Health and Wellness Director at a sister facility. Employee #11 lacked a personnel file with documented evidence of a background check and was performing Health and Wellness duties at this facility. Employee #12 Employee #12 was employed as Maintenance Director at a sister facility. Employee #12 lacked a personnel file with documented evidence of a background check and was performing Maintenance duties at this facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employees #11 and #12 worked at the facility and did not have personnel files maintained in the facility. Severity: 2 Scope: 1	0104	All new hire employees will have NABS screening within 10 calendar days of hire in each employee file currently and on-going. Business Office Coordinator will ensure that all new hires are input in NABS System and Fingerprints are taken prior to beginning employment. There will be a file tracker to document and maintain all employee files. The Business Office Coordinator and Executive Director will be responsible for implementing and maintaining compliance. Exhibit A Attached for Fingerprint Forms for Employees #11 and #12 Business Office Coordinator will ensure that all new hires are input in NABS System and Fingerprints are taken prior to beginning employment. There will be a file tracker to document and maintain all employee files. The Business Office Coordinator and Executive Director will be responsible for implementing and maintaining compliance. Exhibit A Attached for Fingerprint Forms for Employees #11 and #12	12/01/2023

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0174 SS= D	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility was free from offensive odors. Findings include: On 09/21/23 at 10:40 AM, Room 37 had an excessive urine odor. At 12:43 PM, two surveyors returned to the room and stood outside the corridor door. Both surveyors confirmed the odor was still present. On 09/21/23 at 12:55 PM, a surveyor returned to the room with a Caregiver. The Caregiver verbalized there was a strong urine odor in the room. The Caregiver verbalized the room had been deep cleaned the day before; however, the resident would become combative when trying to deep clean the room. Severity: 2 Scope: 1	0174	Apartment 37 was deep cleaned on 10/27/2023 including carpet and heating unit. Regular cleaning schedule is in place and on-going. 1. The Executive Director or designee inspected the community to identify any other rooms in need of deep cleaning. 1. The caregivers and housekeepers will be re-educated on the regular cleaning schedule process as well as the process for deep cleaning. The Executive Director or designee will monitor the community during daily rounds for additional cleaning needs.	12/01/2023
0178 SS= D	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 a resident's room blinds were not broken. On 09/21/23 at 11:15 AM, the blinds in Room 26 were broken in several areas. On 09/21/23 at 11:15 AM, the Maintenance Director confirmed the blinds were broken. Severity: 2 Scope: 1	0178	The blinds in Apartment 26 were replaced. Blinds throughout the community have been inspected, ordered and replaced by 12/1/23. Upon arrival will be installed. 1. The Executive Director or designee inspected the community to identify any other rooms with blinds in need of cleaning or replacement. 1. The caregivers and housekeepers will be re-educated on the regular cleaning schedule process as well as the process for deep cleaning. The Executive Director or designee will monitor the community during daily rounds for additional cleaning needs.	12/01/2023

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0250 SS= D	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure hair restraints were worn by staff in the facility's kitchen and the floors in the dry storage area were clean. Findings include: On 09/21/23 at 9:10 AM, during a tour of the facility's kitchen, one staff member was in the kitchen and was not wearing any form of hair restraint. The one staff member was working with food. The floors underneath the dry storage were dirty. On 09/21/23 at 9:12 AM, the Cook confirmed staff were required to wear hair nets and ponytails were used to restrain hair. The Cook verbalized the kitchen had run out of hair nets and had to go get more from storage. The cook explained the floors in the dry storage were cleaned weekly. On 09/21/23 at 9:21 AM, the Dining Services Coordinator (DSC) verbalized hair nets were to be worn when staff were behind the tray line and cooking food. The DSC explained the dry storage floors were to be cleaned daily and confirmed the floors under the dry storage had not been cleaned. The facility policy titled "Hair Restraints," last revised 04/2019, documented all hair must be kept covered. Acceptable hair restraints were hairnets, white paper hats and cloth chef's hats. The facility policy titled "Cleaning Schedule," last revised 05/2010, documented to serve food in a safe and sanitary manner, a cleaning schedule must be posted and initiated to ensure all cleaning tasks were completed. Severity: 2 Scope: 1	0250	1. The kitchen staff was re-educated on the policy and procedure for hair restraints while in the kitchen. A box of hairnets was purchased. The floor in the dry storage was deep cleaned. The Executive Director or designee inspected the other floors in the kitchen to confirm that they were clean. Hairnets are provided to each kitchen employee and training was provided on 11/8/23 and dry storage was cleaned 11/3/23. 1. The Executive Director or designee will tour the kitchen during daily rounds to inspect for cleanliness and sanitation.	11/10/2023

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
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0252 SS= D	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation and interview the facility failed to discard expired food and ensure perishable foods were properly stored and labeled. Findings include: Expired Foods On 09/21/23 at 9:13 AM, located in the kitchen dry storage was five cans of enchilada sauce with an expiration date of 05/2023. On 09/21/23 at 9:24 AM, located in Country neighborhood refrigerator was a half-gallon of milk expired on 09/13/23, resident take out containers with no date and caregiver food with no labeling. The Caregiver in the Country neighborhood confirmed the milk was expired and should have been discarded. The takeout containers and caregiver food needed to be labeled. On 09/21/23 at 9:26 AM, located in Boat neighborhood refrigerator was a half-gallon of milk expired on 08/09/23 and grated parmesan cheese expired on 05/18/23. The Maintenance Director confirmed the expired food needed to be used or discarded prior to the expiration date. On 09/21/23 at 9:29 AM, located in the Cottage neighborhood refrigerator was a half-gallon of milk expired on 09/18/23. The Caregiver in the Cottage neighborhood confirmed the milk was expired and should have been discarded. On 09/21/23 at 9:52 AM, the Administrator confirmed all food was required to be accurately labeled upon opening and placing in the refrigerator, and expired food items were to be discarded by the expiration date. Label and Storage On 09/21/23 at 9:13 AM, a bowel of cookie dough and a plastic wrap ball of caramel like substance was unlabeled in the walk-in fridge. On 09/21/23 at 9:15 AM, the Cook	0252	The kitchen staff was re-educated on the policy and procedure for labeling food and discarding expired food items. All expired foods were discarded in main kitchen and satellite kitchens. Food is being properly stored and labeled by opening and received dates. 1. The Executive Director or designee will inspect food items in the kitchen during daily rounds to confirm current dates.	11/05/2023

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	confirmed the food should have been labeled before being placed in the fridge. The facility policy titled "Storage of Perishable Food," last revised 05/2010, documented all refrigerated items would be covered and labeled indicating product name and dated when the product was prepared. Severity: 2 Scope: 1			
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. Inspector Comments: Based on observation and interview, the facility failed to post a current menu in areas where they could be seen by residents and their visitors. Findings include: On 09/21/23 at 11:27 AM, no menu was posted in an area where it could be seen by residents and their visitors. On 09/21/23 at 11:27 AM, the Maintenance Director confirmed the facility menu was not posted and retrieved a copy from the kitchen. Severity: 1 Scope: 3	0272	The kitchen staff was re-educated on the policy and procedure to post menus. Current menus posted in common space and in each neighborhood daily and on-going. 1. The Executive Director or designee will look for posted menu in the common areas during daily rounds.	11/03/2023
0450 SS= F	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, document review, and interview, the facility failed to ensure the Administrator and Caregivers received first aid and cardiopulmonary resuscitation (CPR) training within 30 days of employment for 5 of 12 sampled employees working in the facility greater than 30 days (Employee #5, #7, #10, #11, and #12). Findings include: On 09/21/23 at 9:54 AM, the Business	0450	First Aid & CPR completed for employees 5, 7, 10, 11, and 12. First aid and CPR completed for current employee 11/7/23. All certifications will be place in employee file they will be current and on-going. Business Office Coordinator will ensure that all new hires are enrolled and complete CPR/1st Aid Training prior to or within the 1st 30 days of employment. There will be a filetracker to document and maintain all employee files and bi-annual compliance of CPR/1st Aid Certification. The Business Office Coordinator and Executive Director will be responsible for implementing and maintaining compliance. Employees #5, #7, #10 are no	12/01/2023

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	Office Director was provided with the Personnel Check List to complete for 10 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Director provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as Medication Technician with a start date of 04/17/23. Employee #5's personnel file contained first aid and CPR training completed on 05/24/23. Employee #7 Employee #7 was hired by the facility as Programs Assistant with a start date of 05/01/23. Employee #7's personnel file lacked documented evidence of first aid and CPR training completed. Employee #10 Employee #10 was hired by the facility as Caregiver with a start date of 06/22/23. Employee #10's personnel file lacked documented evidence of first aid and CPR training completed. Employee #11 Employee #11 was employed as Health and Wellness Director at a sister facility. Employee #11 lacked a personnel file with documented evidence of a background check and was performing Health and Wellness duties at this facility. Employee #12 Employee #12 was employed as Maintenance Director at a sister facility. Employee #12 lacked a personnel file with documented evidence of a background check and was performing Maintenance duties at this facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employees #11 and #12 worked at the facility and did not have personnel files maintained in the facility. On 09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2		longer employed with the community. Exhibit B Attached for CPR/1st Aid Cards for Employees #11 and #12.	
0590	Rights of Residents; Procedure for Filing -	0590		12/01/202

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SS= F	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: (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; Inspector Comments: Based on record review, document review, and interview the facility failed to protect residents from neglect by not ensuring a Medication Technician (Med Tech) was available to administer morning medications with the potential to effect 34 of 34 residents in the facility and failed to report the incident to the appropriate state agency. Findings include: The staffing roster for August 2023, documented a Med Tech was not available during the 6:00 AM - 2:00 PM shift on 08/19/23. A facility Daily Census Report dated 08/19/23, documented the facility's resident census on 08/19/23 was 34 residents. On 09/21/23 at 10:25 AM, a Med Tech recalled on 08/19/23, a Med Tech scheduled to work the 6:00 AM - 2:00 PM shift did not show up to work. The Med Tech verbalized the residents' Medication Administration Records (MAR) documented no one administered morning medications to residents until the afternoon of 08/19/23. On 09/21/23 at 10:44 AM, the Med Tech recalled a resident's representative was present when no one was available to administer morning medications to residents on 08/19/23, and expressed to the Med Tech someone at the facility had contacted a hospice nurse and asked if the nurse could come help administer medications. On 09/21/23 at 10:57 AM, a Registered Nurse-hospice (RN1) verbalized a hospice nurse (RN2), during a nurse to nurse report, verbalized the facility asked RN2 to administer medications to the facility's residents because the person scheduled to		Community associates will be re-educated on the resident rights policy and the policy on abuse, neglect and exploitation. Community associates will also be re-educated on the community's policy regarding staffing coverage in the event of an absence or no call, no show. Facility will schedule certified med-tech for med pass times employed by facility and monitor on-going scheduling for safety of residents. -The Executive Director and Health and Wellness Director will partner to ensure that any incidents and/or allegations in regards to resident rights and safety are self-reported via the paper or online form on the DPBH/HCQC site within the allotted time frame. The Executive Director will be responsible for follow-upon any and all reports and allegations. Exhibit C Attached form where Health and Wellness Director was trained on the online self-reporting form via the DPBH/HCQC website and paper form.	3

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	administer medications had not shown up to work. On 09/21/23 at 1:12 PM, the Executive Director used pink and purple high lighters to mark when staff scheduled to work did not work including call ins and no show/no call. The facility's August 2023 schedule, documented the Med Tech scheduled to work from 6:00 AM until 2:00 PM on 08/19/23, did not work on 08/19/23 and another Med Tech was not scheduled to work until 2:00 PM. On 09/21/23 at 3:12 PM, the Executive Director explained on 08/19/23, at approximately 7:00 AM to 7:30 AM, the Executive Director was informed the Med Tech scheduled to work from 6:00 AM - 2:00 PM was a no call/no show, the night shift Med Tech had already left for the day, and the Executive Director began calling staff to come in and help. The Executive Director confirmed the Med Tech scheduled to work from 6:00 AM 2:00 PM on 08/19/23, was a no call/no show. The Executive Director verbalized the Executive Director arrived at the facility around 10:00 AM - 10:30 AM, but did not recall the exact time. The Executive Director began administering morning medications to the residents. The Executive Director confirmed asking RN2 to assist by administering medications to RN2's hospice patients. The Executive Director confirmed the facility's morning medication administration pass was not started until the Executive Director arrived at the facility and confirmed all of the morning medications were delivered late. On 09/21/23 at 3:20 PM, the Executive Director verbalized neglect was a type of abuse and confirmed the failure to provide patient care, including the administration of medications was neglect. The Executive Director verbalized a self report to the State should always be completed when abuse, including neglect was present. The Executive Director confirmed a self-report to the State regarding the lack of a Med Tech to administer medications to residents on the morning of 08/19/23, should have been completed and was not. The facility policy			

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	titled "Abuse, Neglect, and Exploitation, NV-1," last revised on 04/2002, documented neglect was defined as the failure of those caring for an older person to provide services necessary to maintain the physical or mental health of the older person. When a determination had been made there reasonable cause to believe a resident had been neglected, the Executive Director or designee reported such information to the local Office of Aging Services Division of the Department of Human Resources. Cross reference with Y0878 Severity: 2 Scope: 3 Complaints #NV00069250 and #NV00069332			

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure a general physical examination was completed on or prior to admission for 1 of 10 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 05/02/23, with a diagnosis of cerebral atherosclerosis. Resident #5's clinical record lacked documented evidence of a general physical examination with a review of systems on or prior to admission. On 09/21/23 at 12:06 PM, the Health and Wellness Director confirmed Resident #5 did not have a physical examination on file and a physical examination was required on admission and annually. Severity: 2 Scope: 1	0859	Resident 5 was scheduled for a physical examination with his/her physician. The Health and Wellness Director reviewed the clinical files for the other residents to verify that a physical examination was present. Facility will not admit residents without a proper PPOC prior to admission. For the next 90 days, the Executive Director will review the clinical file for any new resident before move in to confirm a physical examination was completed in accordance with the rules. The Health and Wellness Director will be responsible for ensuring all residents have a full physical exam with review of systems prior to admission and annually or more frequently if necessary. Exhibit D Attached PPOC for resident #5.	12/01/2023
0878 SS= E	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-	0878	Medications for Residents 3, 10, and 8 were reviewed and any missing medications were obtained from the pharmacy. The medication technicians will be re-educated on medication training policies. 3rd party contracted pharmacy to complete full audit of all residents for each MD order against current orders in community on 11/13/23. Administrator and/or designee will ensure all medications will have MD orders and supply on-going.	12/01/2023

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	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 must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (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 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, the 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 record review, observation, document review and interview, the facility failed to ensure 1) medications were on-site to administer as prescribed for 3 of 10 sampled residents (Resident #3, #10, and #8), and 2) medications were administered per physician's order for 1 of 10 sampled residents (Resident #1). Findings include: Resident #3 Resident #3 was admitted to the facility on 06/20/23, with diagnoses including unspecified dementia, post traumatic stress disorder and hyperlipidemia. On 09/21/23 at 11:20 AM, during a review of the resident's medications, losartan potassium oral tablet		1. For the next 90 days, the Health and Wellness Director will review the medication orders for two residents weekly against the medications in the med cart to confirm they are available as prescribed.	

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	25 milligram (mg) tablet, give one tablet by mouth one time a day for hypertension and trazadone oral tablet 50 mg, give one tablet by mouth in the evening for sleep was not located. A physician's order dated 06/13/23, documented losartan 25 mg tablet, take one tablet by mouth once day for hypertension. A physician's order dated 06/22/23, documented trazadone oral tablet 50 mg, give one tablet by mouth in the evening for sleep. On 09/21/23 at 11:26 AM, the Medication Technician confirmed losartan 25 mg tablet and trazadone 50 mg tablet were not on-site and available to administer to Resident #3. Resident #10 Resident #10 was admitted to the facility on 05/26/23, with diagnoses including dementia and hypertension. On 09/21/23 at 11:28 AM, during a review of the resident's medications, milk of magnesia oral suspension, give 30 milliliters by mouth every 72 hours as needed for constipation, amlodipine besylate oral tablet 5 mg, give one tablet by mouth one time a day for 30 days, and atorvastatin calcium 40 mg tablet, give one 40 mg tablet by mouth at bedtime related to hyperlipidemia was not located. A physician's order dated 06/01/23, documented milk of magnesia oral suspension, give 30 milliliters by mouth every 72 hours as needed for constipation, and atorvastatin calcium 40 mg tablet, give one 40 mg tablet by mouth at bedtime related to hyperlipidemia. A physician's order dated 09/21/23, documented amlodipine besylate oral tablet 5 mg, give one tablet by mouth one time a day for 30 days. On 09/21/23 at 11:34 AM, the Medication Technician confirmed milk of magnesia oral suspension, amlodipine besylate oral tablet 5 mg, an atorvastatin calcium 40 mg tablet, were not on-site and available to administer to Resident #10. Resident #8 Resident #8 was admitted to the facility on 07/31/23, with diagnoses including Alzheimer's disease, morbid obesity, depression and anxiety. On 09/21/23 at 1:17 PM, during a review of the			

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	resident's medications, the following medications were not located: - calcium-vitamin D tablet 600 mg-200 units, give one tablet by mouth once a day for supplementation. - milk of magnesia suspension 400 mg/5 milliliters (ml), give 30 ml by mouth every 24 hours as needed for constipation. - Norco oral tablet 5-325 mg, give one tablet by mouth every four hours as needed for severe pain A physician's order dated 07/25/23, documented the following medications: - calcium-vitamin D tablet 600 mg-200 units, give one tablet by mouth once a day for supplementation. - milk of magnesia suspension 400 mg/5 milliliters (ml), give 30 ml by mouth every 24 hours as needed for constipation. - Norco oral tablet 5-325 mg, give one tablet by mouth every four hours as needed for severe pain On 09/21/23 at 1:29 PM, the Medication Technician confirmed calcium-vitamin D tablet 600 mg-200 units, milk of magnesia suspension 400 mg/5 ml, and Norco oral tablet 5-325 mg were not on-site and available to administer to Resident #8. Resident #1 Resident #1 was admitted to the facility on 05/26/23, with diagnoses including dementia, chronic obstructive pulmonary disease, hyperlipidemia, hypertension and tobacco use. On 09/21/23 at 12:50 PM, during review of the resident's medications, Resident #1's medication container documented lisinopril 10 mg. A physician's order dated 05/27/23, documented lisinopril 5 mg, take one tablet by mouth one time a day for hypertension. Resident #1's September 2023 Medication Administration Record (MAR) documented lisinopril 5 mg, take one tablet by mouth one time a day for hypertension. Resident #1's September 2023 MAR documented the lisinopril medication was administered daily from September 1st though 20th. On 09/21/23 at 12:56 PM, the Medication Technician confirmed the medication administered to Resident #1 was lisinopril 10 mg and not the correct dosage per the physician's order of lisinopril 5 mg. The			

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	medication Technician verbalized the physician had not been informed of the medication error. Severity: 2 Scope: 2			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, interview, document review, and clinical record review, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 10 sampled residents (Resident #3 and #10). Findings include: Resident #3 Resident #3 was admitted to the facility on 06/20/23, with diagnoses including unspecified dementia, post traumatic stress disorder, and hyperlipidemia. On 09/21/23, during medication review, the following medication was available in the medication cart for Resident #3: -escitalopram oxalate oral tablet 10 milligram (mg), give one tablet by mouth on time a day for behaviors. -folic acid tablet 1 mg, give one tablet by mouth for supplementation -bisacodyl suppository, insert rectally as needed for constipation not resolved with polyethylene glycol 3350 or milk of magnesia The September 2023 MAR for Resident #3 included escitalopram oxalate tablet for 5 mg. The September 2023 MAR did not include the folic acid, and bisacodyl suppository. A Physician's order dated 06/20/23, documented the following: -	0895	Medication Administration Records for Residents 3 and 10 were reviewed and updated. The medication technicians will be re-educated on medication training policies. 3rd party contracted pharmacy to complete full audit of all residents for each MD order against current orders in community on 11/13/23. Administrator and/or designee will ensure all medications will have MD orders and supply on-going. 1. For the next 90 days, the Health and Wellness Director will review the medication administration records for two residents weekly against physician orders to confirm they are as prescribed.	12/01/2023

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	escitalopram oxalate tablet 10 mg, give one tablet by mouth daily for moods -folic acid tablet 1 mg, give one tablet by mouth for supplementation -bisacodyl suppository, insert rectally as needed for constipation not resolved with polyethylene glycol 3350 or milk of magnesia On 09/11/23 at 11:20 AM, the Medication Technician explained the escitalopram was ordered for 10 mg and the MAR indicated 5 mg. The Medication Technician confirmed folic acid and bisacodyl suppository was in the medication cart, however, not on the resident's MAR. Resident #10 Resident #10 was admitted to the facility on 05/26/23, with diagnoses including unspecified dementia and hypertension. On 09/21/23, during medication review, the following medication was available in the medication cart for Resident #10: -acetaminophen tablet 650 mg tablet, give one tablet by mouth every six hours as needed for mild pain or fever. -loperamide hydrochloride (HCL) 2 mg tablet, take one tablet by mouth four times a day as needed for diarrhea. The September 2023 MAR for Resident #10 included acetaminophen tablet 650 mg tablet, give one tablet every four hours for general discomfort and loperamide HCL 2 mg tablet, give one tablet every six hours as needed for diarrhea. A Physician's order dated 06/20/23, documented the following: -acetaminophen tablet 650 mg tablet, give one tablet by mouth every six hours as needed for mild pain or fever. -loperamide hydrochloride (HCL) 2 mg tablet, take one tablet by mouth four times a day as needed for diarrhea. On 09/11/23 at 11:34 AM, the Medication Technician confirmed the acetaminophen and loperamide medication on the cart did not match the September 2023 MAR. Severity: 2 Scope: 1			
0936 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential	0936	Attached are completed TB tests for Residents #10, #5 and #6. Resident #2 no longer resides at the Community. The Health and Wellness Director or	01/04/2024

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	facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure 4 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #10, #5, #2, and #6). Findings include: Resident #10 Resident #10 was admitted to the facility on 05/26/23, with diagnoses including dementia and hypertension. Resident #10's file contained a first step TB test administered on 05/12/23, however, the test lacked a read date. The resident's record lacked documented evidence of a second step TB test upon admission. On 09/21/23 at 12:02 PM, the Health and Wellness Director (HWD) confirmed Resident #10 lacked evidence of a completed first step and a second step TB test upon admission. Resident #5 Resident #5 was admitted to the facility on 05/02/23, with a diagnosis of cerebral atherosclerosis. Resident #5's record documented a two step TB test with the first step given on 06/23/23 at 12:00 PM and read negative on 06/26/23 at 10:15 AM. The second step was given on 07/03/23 at 12:00 AM and read negative on 07/05/23 at 12:15 PM. The two step TB test was initiated more than five days after Resident #5's admission date. On 09/21/23 at 12:06 PM, the HWD confirmed the TB test was late and should have been initiated within five days of the resident's admission. Resident #2 Resident #2 was admitted to the facility on 08/14/23, with diagnoses		designee will review the clinical files for the other residents to confirm the necessary TB test is present. If not, the resident will receive the required TB testing. Facility designee will complete retest of TB tests for all residents. Tb tests will be completed on date of move in and read within 48/72 hours current and on-going annually. 1. The Executive Director will review five resident files monthly for the next six months to confirm that the required TB skin testing is present. Updated TB tests attached per request.	

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	including dementia and glaucoma. Resident #2's clinical record lacked documentation of a TB test at admission. On 09/21/23 at 12:16 PM, the HWD confirmed a two step TB test or QuantiFERON had not been completed for Resident #2 at admission. Resident #6 Resident #6 was admitted to the facility on 05/31/22, with diagnoses including dementia, hypertension, and hyperlipidemia. Resident #6's clinical record documented a TB test administered on 06/01/22 and read on 06/03/22. The clinical record lacked an annual TB test for 2023. On 09/21/23 at 12:15 PM, the HWD confirmed Resident #6 lacked an annual TB test for 2023. Severity: 2 Scope: 2			
0938 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure an initial or annual Activities of Daily Living (ADL) assessment	0938	An ADL assessment will be completed for residents 8, 3, 10, 5, and 6.The Health and Wellness Director or designee will review the clinical files for the other residents to confirm the required ADL assessment is present. If not, an ADL assessment will be completed. All ADL assessments will be completed initially, as needed, and every six months currently and on-going. Administrator and/or designee will monitor. 1. The Executive Director will review five resident files monthly for the next six months to confirm that the required ADL assessment is present.	12/01/2023

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	was completed for 5 of 10 sampled residents (Resident #5, #8, #3, #10, and #6). Findings include: Resident #5 Resident #5 was admitted to the facility on 05/02/23, with a diagnosis of cerebral atherosclerosis. Resident #5's clinical record documented an initial ADL assessment dated 05/02/23, however, the assessment lacked documented evidence the assessment was completed by the facility. On 09/21/23 at 12:06 PM, the Health and Wellness Director (HWD) confirmed Resident #5's ADL assessment lacked evidence of completion by the facility. Resident #8 Resident #8 was admitted to the facility on 07/31/23 with diagnoses including Alzheimer's disease, morbid obesity, depression and anxiety. Resident #8's clinical record documented an initial ADL assessment dated 08/01/23, however, the assessment lacked documented evidence the assessment was completed by the facility. On 09/21/23 at 11:50 AM, the HWD confirmed confirmed Resident #8's ADL assessment lacked evidence of completion by the facility. Resident #3 Resident #3 was admitted to the facility on 06/20/23, with diagnoses including unspecified dementia, post-traumatic stress disorder, and hyperlipidemia. Resident #3's clinical record documented an initial ADL assessment was completed on 06/20/23, however, lacked documented evidence the assessment was completed by the facility. Resident #10 Resident #10 was admitted to the facility on 05/26/23, with diagnoses including dementia and hypertension. Resident #10's clinical record documented an initial ADL assessment was completed on 05/26/23, however, lacked documented evidence the assessment was completed by the facility. On 09/21/23 at 12:02 PM, the HWD confirmed the ADL assessments for Residents #3 and #10, lacked evidence the ADL assessment was completed at admission by the owner, caregiver, or the administrator. Resident #6 Resident #6 was admitted to the facility on 10/23/22 with a			

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	diagnosis of Alzheimers and cataracts. Resident #6's clinical record documented an initial ADL assessment dated 10/21/22, however, the assessment lacked documented evidence the assessment was completed by the facility. On 09/21/23 at 12:08 PM, the Health and Wellness Director (HWD) confirmed Resident #6's ADL assessment lacked evidence of completion by the facility. Severity: 2 Scope: 3			
0966 SS= F	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on interview and document review, the facility failed to ensure there was staffing of one Caregiver for every six residents during residents' waking hours in an Alzheimer's endorsed facility. Findings include: Review of the July 2023 and August 2023 staffing schedules documented the facility failed to provide a minimum of one caregiver to six residents residing at the facility, which was endorsed for Alzheimer's Disease, as follows. July 2023 The facility provided Daily Census sheets for four of 31 days in July 2023, and lacked documented evidence of the resident census on the remaining 27 days. The census for July 2023 was 35 -36 residents each day, per the available census sheets provided by the facility, requiring a minimum of six caregivers during resident waking hours. Staffing was not met on the following date during the noted hours: -07/01/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including two Medication	0966	1. The current staffing schedule was reviewed to confirm that there is a minimum of one caregiver to six residents scheduled during waking hours. The Health and Wellness Director or designee will be re-educated on the minimum staffing requirements for an Alzheimer's endorsed facility. Facility will schedule staffing to comply with 6:1 ratio during waking hours currently and on-going. Administrator and/or designee will monitor. 1. For the next 90 days, the Executive Director or designee will review the staffing schedule weekly to confirm that the 6:1 minimum staffing ratio is satisfied.	12/01/2023

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	Technicians (Med Tech) and one Clare Bridge Program Assistant (CBPA). -07/03/23 between the hours of 6:00 AM to 2:00 PM, there were five caregivers, including two Med Techs. -07/23/23 between the hours of 6:00 AM to 2:00 PM, there were five caregivers, including two Med Techs and two Med Tech/Caregivers. On 09/21/23 at 4:15 PM, the facility was not able to provide a Daily Census Report for 07/01, 07/03, and 07/23/23. August 2023 The facility provided Daily Census sheets for seven of 30 days in August 2023, and a resident list for two of 30 days in August. The facility failed to provide documented evidence of the resident census on the remaining 21 days. The census for August 2023 was 34 - 37 residents each day, per the available census sheets provided by the facility, requiring six to seven caregivers during resident waking hours. Staffing was not met on the following dates during the noted hours: -08/07/23 between the hours of 6:00 AM to 2:00 PM, there were five caregivers, including two Med Techs. Between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including one Med Tech and one CBPA. The Daily Census report for 08/07/23, provided by the facility, documented a resident census of 37 indicating the need for seven caregivers. -08/12/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including two Med Techs and one CBPA. -08/13/23 between the hours of 6:00 AM and 2:00 PM, there were five care givers, including three Med Techs and one CBPA. The Daily Census report for 08/13/23, provided by the facility, documented a resident census of 34 indicating the need for six caregivers. -08/14/23 between the hours of 6:00 AM and 2:00 PM, there were five care givers, including two Med Techs. The Daily Census report for 08/14/23, provided by the facility, documented a resident census of 34 residents, indicating the need for 6 caregivers. -08/19/23 between the hours of 6:00 AM to 2:00 PM,			

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	there were five caregivers, including one CBPA. Between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including one Med Tech and one CBPA. The Daily Census report for 08/19/23, provided by the facility, documented a resident census of 34 indicating the need for six caregivers. -08/21/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including one Med Tech and one CBPA. The Daily Census report for 08/21/23, provided by the facility, documented a resident census of 34 indicating the need for six caregivers. -08/27/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including two Med Techs and one CBPA. On 09/21/23 at 4:15 PM, the facility was not able to provide a Daily Census Report for 08/12 and 08/27/23. September 2023 The facility provided a daily list of residents for 10 of 21 days in September 2023. The facility failed to provide documented evidence of the resident census on the remaining 11 days. The census for September 2023 was 31-33 residents each day, per the available daily list of residents provided by the facility, requiring six caregivers during resident waking hours. Staffing was not met on the following dates during the noted hours: -09/03/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including two Med Techs. -09/07/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including two Med Techs and one CBPA. The daily resident list for 09/07/23 documented a resident census of 31 indicating the need for 6 caregivers. -09/17/23 between the hours of 2:00 PM to 10:00 PM, there were five caregivers, including two Med Techs. On 09/21/23 at 4:15 PM, the facility was not able to provide a Daily Census Report for 09/03 and 09/17/23. On 09/21/23 at 3:25 PM, the Executive Director confirmed the ratio of 1:6 (Caregivers - residents) was required and confirmed the facility failed to meet the			

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	caregiver to resident ratio of 1:6 during the months of July, August, and September 2023. The facility policy titled "Staffing Requirements Policy, NV-6," dated 03/2023, documented staffing was based on resident need and met the staffing requirements for Alzheimer's disease and related dementia in Nevada. Cross reference with tag Y0088. Severity: 2 Scope: 3 Complaint #NV00069332 and #NV00069250			
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure dangerous items were inaccessible to residents housed in the memory care unit for 33 of 33 residents. Findings include: On 09/21/23 at 10:18 AM, Room 24 had a push pin in the wall. On 09/21/23 at 10:42 AM, Room 40 had a book of matches and a lighter in a dresser drawer. On 09/21/23 at 10:18 AM through 10:42 AM, the Maintenance Director confirmed the above-mentioned items could be dangerous to residents in the memory care unit and should be secured. The facility policy, "Resident Personal Care Items - ALZ-5," documented, "it is important that all areas of the community are made as safe as possible." Severity: 2 Scope: 3	0994	The memory care unit was inspected and any inappropriate items were removed. Inspected apartments for all working locking devices in each apartment. Training was provided to all staff keeping residents from dangerous items. Administrator and/or designee will conduct regular sweeps of the apartments and family education on-going.	11/10/2023

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview the facility failed to ensure resident safety in the memory care unit by securing hazardous chemicals for 33 of 33 residents. Findings include: On 09/21/23, the following toxic items were present: - At 10:08 AM, in Room 17's unlocked bathroom cabinet, there were: - 32-ounce Head & Shoulders 2-in-1 - 2 eight-ounce containers of Aveeno lotion - a four-ounce container of intensive skin care lotion - At 10:40 AM, in Room 27, there were: - three packages of skin prep - At 10:26 AM, in Room 32, there was: - a six-ounce tube of Colgate Optic White toothpaste on the bathroom sink - At 10:35 AM, in Room 34, there were: - two alcohol prep pads in a drawer - At 10:42 AM, in Room 40, there were - six Polident tabs in the bathroom - six Polident tabs in the dresser drawer On 09/21/23 at 10:08 AM through 10:42 AM, the Maintenance Director confirmed the items were accessible to residents and not secured. The facility policy, "Resident Personal Care Items - ALZ-5," documented, "it is important that all areas of the community are made as safe as possible." Severity: 2 Scope: 3	0999	Inspected apartments for all personal care items in each apartment. Training was provided to all staff keeping residents from dangerous items. Administrator and/or designee will conduct regular sweeps of the apartments and family education on-going 1. For the next 90 days, the Executive Director or designee will tour the memory care unit daily to verify that inappropriate items are not on the unit available to residents.	12/01/2023
1001	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those	1001	Elderly care training has been completed for Employee 6, 10, and 11. Employees 5, 7, and 9 are no longer with the facility. All required training was completed by 11/10/23 and administrator and/or designee will monitor for current required initial and annual training on-going. The Business Office	12/01/2023

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	residents. Inspector Comments: Based on record review and interview, the facility failed to ensure 6 of 6 sampled employees working at the facility greater than 60 days and less than one year received four hours of initial training to care for elderly or disabled residents, within 60 days of hire (Employee #5, #6, #7, #9, #10, and #11). Findings include: On 09/21/23 at 9:54 AM, the Business Office Director was provided with the Personnel Check List to complete for 12 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Manager provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as Medication Technician with a start date of 04/17/23. Employee #5's personnel file lacked documented evidence of training to care for elderly and disabled residents. Employee #6 Employee #6 was hired by the facility as Caregiver with a start date of 05/15/23. Employee #6's personnel file lacked documented evidence of training to care for elderly and disabled residents. Employee #7 Employee #7 was hired by the facility as Program Assistant with a start date of 05/01/23. Employee #7's personnel file lacked documented evidence of training to care for elderly and disabled residents. Employee #9 Employee #9 was hired by the facility as Medication Technician with a start date of 01/04/23. Employee #9's personnel file lacked documented evidence of training to care for elderly and disabled residents. Employee #10 Employee #10 was hired by the facility as Caregiver with a start date of 06/22/23. Employee #10's personnel file lacked documented evidence of training to care for elderly and disabled residents. Employee #11 Employee #11 lacked a personnel file kept at the facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employees #11 and #12 worked at the facility and did not have personnel files maintained in the facility. On		Manager or designee will review the personnel files of other associates to verify that elderly care training has been completed. Elderly care training will be offered to other employees as needed.	

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		A. BUILDING _____ B. WING _____	**09/21/2023**

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	09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			
1036 SS= F	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 7 of 12 sampled employees working at the facility greater than 90 days received eight hours of dementia training within 90 days of the employees' start date for 4 of 6 employees (Employee #5, #7, #9, and #11). Findings include: On 09/21/23 at 9:54 AM, the Business Office Director was provided with the Personnel Check List to complete for 10 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Manager provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as	1036	All required training will be completed by 12/1/23 and administrator and/or designee will monitor for current required initial and annual training on-going. Employee 9 is the only remaining employee since inspection. 1. The Business Office Manager or designee will review new associate personnel files to confirm that dementia care training has been completed within 90 days of hire. During the on-boarding process, the Business Office Coordinator will ensure all new hires have completed the required Dementia/Alzheimer's Disease Training within the 1st 90 days of employment via orientation and on-going training. There will be a file tracker to document and maintain all employee files. The Business Office Coordinator and Executive Director will be responsible for implementing and maintaining compliance.	12/01/2023

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

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	Medication Technician with a start date of 04/17/23. Employee #5's personnel file lacked 2.75 hours of the required eight hours of dementia training by 90 days of employment. Employee #7 Employee #7 was hired by the facility as Program Assistant with a start date of 05/01/23. Employee #7's personnel file lacked two hours of the required eight hours of dementia training by 90 days of employment. Employee #9 Employee #9 was hired by the facility as Medication Technician with a start date of 01/04/23. Employee #9's personnel file lacked 2.75 hours of the required eight hours of dementia training by 90 days of employment. Employee #11 Employee #11 lacked a personnel file kept at the facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employee #11 worked at the facility and did not have personnel files maintained in the facility. On 09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			
1037 SS= F	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational	1037	All required training will be completed by 12/1/23 and administrator and/or designee will monitor for current required initial and annual training on-going. 1. The Business Office Manager or designee will review new associate personnel files to confirm that additional dementia care training has been completed by their anniversary date. There will be monthly In-service meetings with some topics covering Alzheimer's Disease/Dementia Care to	12/01/2023

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	licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 2 employees completed the required minimum of additional three hours of training in providing care to a resident with dementia by the hire anniversary date (Employee #4 and #11). Findings include: On 09/21/23 at 9:54 AM, the Business Office Director was provided with the Personnel Check List to complete for 10 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Manager provided the completed form with the following information: Employee #4 Employee #4 was hired at the facility as Medication Technician with a start date of 04/28/22. Employee #4's personnel file contained documented evidence of one hour of annual dementia training. Employee #11 Employee #11 lacked a personnel file kept at the facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employee #11 worked at the facility and did not have		ensure that all staff have on-going training and meet the required 3 annual hours. The Health and Wellness Director or Executive Director will conduct the training while the Business Office Coordinator keeps a file tracker to document and maintain all employee files. The Business Office Coordinator, Health and Wellness Director and Executive Director will be responsible for implementing and maintaining compliance.	

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	personnel files maintained in the facility. On 09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			
1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 4 of 9 sampled employees required to obtain cultural competency training (Employee #3, #4, #5, and #9). Findings include: On 09/21/23 at 9:54 AM, the Business Office Director was provided with the Personnel Check List to complete for 10 sampled employees. On 09/21/23 at 1:05 PM, the Business Office Manager provided the completed form with the following	1540	All required training will be completed by 12/1/23 and administrator and/or designee will monitor for current required initial and annual training on-going. 1. The Business Office Manager or designee will review new associate personnel files to confirm that cultural competency training has been completed. 1. The Business Office Manager or designee will review the personnel files of other associates to verify that cultural competency training has been completed. This training will be offered to other employees as needed. Community associates have been re-educated on the requirement to complete such training within 30 days.	12/01/2023

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	information: Employee #4 Employee #4 was hired at the facility as Medication Technician with a hire date of 04/15/22. Employee #4's personnel file contained a cultural competency training certificate dated 07/01/23. Employee #5 Employee #5 was hired by the facility as Medication Technician with a hire date of 03/27/23. Employee #5's personnel file contained a cultural competency training certificate dated 05/30/23. Employee #6 Employee #6 was hired by the facility as Caregiver with a hire date of 05/12/23. Employee #6's personnel file contained a cultural competency training certificate dated 07/01/23. Employee #7 Employee #7 was hired by the facility as Program Assistant with a start date of 04/14/23. Employee #7's personnel file contained a cultural competency training certificate dated 06/01/23. Employee #10 Employee #10 was hired by the facility as Caregiver with a hire date of 06/16/23. Employee #10's personnel file lacked a cultural competency training certificate. Employee #11 Employee #11 lacked a personnel file kept at the facility. On 09/21/23 at 12:16 PM, the Executive Director confirmed Employee #11 worked at the facility and did not have personnel files maintained in the facility. On 09/21/23 at 2:27 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/21/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			

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1825 SS= F	I C Program Responsible Person and Designee 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 potentially affecting 33 of 33 residents. Findings include: On 09/21/23 at 10:27 AM, the Executive Director verbalized the facility had not designated a primary and secondary person responsible for the facility's infection control program. Severity: 2 Scope: 3	1825	Designee and secondary will complete required initial and ongoing training to comply with Infection Control regulation. 1. Community associates have been educated on who are the primary and secondary persons responsible to the infection control program. 1. The Executive Director or designee will update the persons serving in these roles if needed. The Resident Care Coordinator will be the primary and the Health & Wellness Director will be the secondary person responsible for the community's infection control program.	01/04/2024
1830 SS= F	Infection Control Required 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 potentially affecting 33 of 33 residents. Findings include: On 09/21/23 at 10:27 AM, the Executive Director confirmed the required infection control and prevention training had not been completed by any employee working in the facility. Severity: 2 Scope: 3	1830	Designee and secondary will complete required initial and ongoing training to comply with Infection Control regulation. The Executive Director or designee will confirm that the persons serving in these roles have received the necessary training.	12/01/2023