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 _____	**06/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON VALLEY RESIDENCE, LLC	**705 SOUTH STREET, YERINGTON, NEVADA ,89447**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a grading resurvey State Licensure survey and complaint investigations conducted in your facility on 06/01/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 57 Residential Facility for Group beds for elderly or disabled persons, and/or persons with Alzheimer's disease, 45 Category II residents and 12 Category II Alzheimer's residents. The census at the time of the survey was 46. Eight resident files and seven 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 #NV00068620 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: Lack of reporting abuse/neglect to proper authority Allegation #2: Resident to Resident Altercation/Abuse Allegation #3: Facility failed to honor resident physician preference. The investigation into the allegations included: Observations of eight residents in the resident's room, Resident to Resident interaction and staff interactions. Interviews were conducted with eight residents, the Administrator, the Resident Care Coordinator, and a Caregiver/Medication	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROSEMARY A ORANTES | Title: Administrator | Date: 08/09/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Technician. Complaint #NV00068615 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: Resident Dehydration Allegation #2: Managing resident insulin. The investigation into the allegations included: Observations of eight residents in the resident's room. Interviews were conducted with Medication Technicians, the Administrator and the Resident Care Coordinator. 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, 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 Y0072, Y0102, Y0104, Y0870, Y0876, Y0878, Y0936, Y0938, Y0994, Y0999, Y1010, Y1520, and Y1700. This was a repeat deficiency from the 02/07/23 annual survey and the 09/13/22 infection control and prevention plan survey. Severity: 2 Scope: 3	0050	SOD reviewed	07/21/2023

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0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate.	0053	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.	0065	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
0072 SS= D	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 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	0072	1. It was found that our medication tech license had lapsed; we informed the medication technician of this. The medication tech decided she did not renew and she was demoted to caregiver. The medication tech decided to resign. Her termination of employment is attached. 2. We have a new medication technician supervisor, a nurse, to help us educate our medication techs as well as keep up on the renewals of the licenses. 3. By having a designated HR along with a new medication tech supervisor the monitoring of the certificates will be scheduled prior to the expiration of the license. 4. Med Tech supervisor, HR 5.. 6/18/23	06/18/2023

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	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 employee personnel file review and interview, the facility failed to ensure 1 of 7 sampled employees, who administered medication, received at least eight hours of Medication Management training annually (Employee #1). Findings include: Employee #1 Employee #1 was hired as a Medication Technician with a start date of 12/29/20. Employee #1's personnel file contained an initial medication management training for sixteen hours dated 02/25/22. The employee's personnel file lacked annual medication management training for 2023. Resident #4's May 2023 Medication Administration Record (MAR) and Resident #7's May 2023 MAR documented Employee #1 administered medications to Resident #4 and Resident #7 on 05/01, 05/07, 05/08, 05/09, 05/10, 05/14, 05/15, 05/21, 05/22, 05/23, 05/24, 05/28, 05/29, and 05/30 without a current medication management certification. On 06/01/23 at 1:48 PM, the Administrator confirmed Employee 1's annual medication management training had not been completed in 2023 and eight hours of annual medication management training was required. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 1			
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility	0074	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023

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	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 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			

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	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 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			

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	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.			
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 2 of 7 sampled employees completed tuberculin (TB) testing (Employee #3 and #6), and 1 of 7 employees completed a physical examination prior to working (Employee #7). Findings include: Employee #3 Employee #3 was hired as a Maintenance Worker with a start date of 04/23/18. Employee #3's personnel file documented an annual TB test given on 07/13/21 at 10:05 AM and read negative on 07/15/21 at 4:05 PM. Employee #3 lacked TB testing for 2022. On 06/01/23 at 1:41 PM, the Administrator confirmed Employee #3 did not have a TB test completed for 2022. Employee #6 Employee #6 was hired as Caregiver with a start date of 05/16/23. Employee #6's personnel file documented a one step TB test administered on 02/28/23 at 1:32 PM and read negative on 03/03/23 at 9:30 AM. However, Employee #6's personnel file lacked documented evidence of a second TB test. On 06/01/23 at 1:39 PM, the Administrator confirmed Employee #6 only had one single step TB test upon hire and did not have documented evidence of a second step TB test. Employee #7 Employee #7 was hired as a Caregiver with a start date of 05/16/23. Employee #7's personnel file lacked documented evidence of a physical examination with a review of	0102	1. We have identified the issue with the annual TB's and the official HR admin is now doing a monthly and keeping an ongoing record of tb's due. We are working with an outside agency that is now coming to our building to complete annual tb's for us. We were also informed of what was not being found in the H&P's that physicians were writing for our employees when they did not use the form given. We have instructed employees they must use our in house physician, Dr. Hefflin for the annuals, or use the form when they go to a physician of their choice. This is to avoid any missed requirements. Employee #7 is now terminated due to his background check. Employee #3 had her second however it wasn't recorded on the document and she was able to get that completed. Employee #3 completed a full 2 step. 2. By using the audit tool, a shared online calendar, and using our outside resources we will be able to keep in compliance. We were struggling with finding a local agency in Yerington that was both affordable and could provide services to us. We now have a physician to help us. 3. By having a licensed RN and or physician in house every other week we should be able to meet the annual requirements with using our audit tool. Also, by having a now designated HR the outstanding requirements will be met more easily and on time. 4. HR Supervisor 5. 7/5/23	07/05/2023

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	systems and statement concerning communicable diseases signed by a physician upon hire. On 06/01/23 at 1:32 PM, the Administrator confirmed Employee #7 lacked a physical exam with a review of systems and free of communicable disease statement signed by a provider. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 2			

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0104 SS= E	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 2 of 7 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #3 and #6). Findings include: Employee #3 Employee #3 was hired as a Maintenance Worker with a start date of 04/23/18. Employee #3's personnel file documented initial fingerprints taken upon hire dated 04/11/18. The employee's personnel file lacked documented evidence of fingerprints being submitted for the five year renewal and evidence of a Nevada Automated Background Check System (NABS) Clearance Letter for the facility. Employee #6 Employee #6 was hired as a Caregiver with a start date of 05/16/23. Employee #6's personnel file lacked documented evidence of fingerprints being submitted and evidence of a NABS Clearance Letter for the facility. The NABS Internet website was searched using the two employees' social security numbers with no results of fingerprints having been submitted for screening. The facility's online NABS account did not reflect the two employees being screened for the facility. On 06/01/23 at 1:45 PM, the Administrator verbalized Employee #3 had not been fingerprinted for the five year renewal and the facility had submitted Employee #6's fingerprints to the Central Repository for screening by mail but did not have a copy of the fingerprints. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 2	0104	1. Unfortunately, we had just started running employee #3's new background and had to stop processing the night prior to this re-survey. The background has been ran and prints were taken on 6/7/23. As for employee #7 his prints were done and background results returned as "ineligible". Employee #7 was terminated. Facility was educated on the importance of photo copying the print cards and keeping in chart to ensure that prints are done within 10 days of start 2. Since obtaining a new HR, and the requirement of keeping a copying of the prints in the employee chart, all employees are being printed at time of offer of employment and a copy is kept in the file. 3. Interviewer understands that time of pre-employment offer print, background and tb are to be done and completed prior to start date. Interviewer offers employment and the new employee is sent over to HR to get the process of hiring started. 4. HR 5. 7/12/2023	07/12/2023

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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.	0450	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or	0557	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
0620 SS= D	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, 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.	0620	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023

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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.	0859	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and clinical record review, the facility failed to ensure a resident admitted for six months or greater had a review of medications for accuracy and appropriateness for 1 of 8	0870	1. This resident is currently a hospice patient and missed from the cycle due to his meds not being with the main pharmacy. The hospice agency was informed of the requirement. A document showing review was done. 2. The facility is currently working with hospice agencies to get a 6 month pharmacy review form done 3. The med tech supervisor will be working with the hospice agencies as well as the administrator to ensure one is done for each resident when its due 4. Med Tech Supervisor/Administrator 5. 06/01/2023	06/01/2023

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MASON VALLEY RESIDENCE, LLC	**705 SOUTH STREET, YERINGTON, NEVADA ,89447**

(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
	sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 03/29/22, with diagnoses including vascular dementia, and hypertension. Resident #5's clinical record lacked documented evidence medication reviews had been completed no later than six months after admission to the facility and subsequently every six months after. On 06/01/23 at 3:30 PM, the Administrator confirmed Resident #5 lacked evidence of six month medication reviews and verbalized medication reviews were to be completed no later than six months after admission to the facility and every six months thereafter. Severity: 2 Scope: 1			
1520 SS= C	Copy of Statement/Filing a Complaint - R016-20 Section 11 1. Upon admission of a patient or resident, the facility shall: (a) Provide the patient or resident with a written copy of the statement required pursuant to paragraph (b) of subsection 2 of NRS 449.101 and the notice and information required pursuant to subsection 3 of NRS 449.101 or section 9 of this regulation, as applicable. (b) Provide the patient or resident with a written notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the facility. The written notice provided by the facility must include, without limitation: (1) The contact information for the Division; (2) A clear statement that such a complaint with the facility: (I) May be filed in addition to the complaint that may be filed with the Division pursuant to subsection 3 of NRS 449.101 or section 9 of this regulation, as applicable; and (II) Is not required to be filed for the patient or resident to file a complaint with the Division pursuant to subsection 3 of NRS 449.101 or section 9 of this regulation, as applicable; and (3) The procedure that the facility uses to address such complaints with the facility and the timeframe for how long it will take the facility to address such complaints with the facility. 2. As used in this section, "prohibited discrimination" means the discrimination described in	1520	1. These resident's forms were not updated for the following reasons:Resident #6 refused to sign and is currently out of the building and will not be returning. Resident #4 signed a new form however it wasn't filed timely. Resident #5, was waiting on guardian to sign. 2. The old form has been removed from the original packet, and the new form has been put in. All copies of the old packet that may have the old form has been sent to trash. 3. With a clean original having the correct form, this issue should not arise again. 4. Administrator 5. 6/1/2023	06/01/2023

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	section 7 of this regulation and in subsection 1 of NRS 449.101. Inspector Comments: Based on document review and interview the facility failed to provide upon admission the contact information for the Division where a resident, who had experienced prohibited discrimination, may file a complaint for 3 of 8 sampled residents (resident #5, #6, and #4). Resident #5 was admitted to the facility on 03/09/22, with diagnoses including dementia, hyperplasia, major depressive disorder. Resident #5's clinical record lacked documented evidence of non-discrimination form with the information to contact the State Agency to file a complaint. Findings include: On 06/01/23 at 3:05 PM, the Administrator verbalized the State Agency complaint/non-discrimination information needed to be provided to the residents at the time of admission and stated that an audit had been done to previous resident files to ensure that this information was provided to all residents within the facility. The Administrator confirmed that resident's listed above must have been missed by error and was not located in resident files. Resident #6 Resident #6 was admitted to the facility on 05/29/14, with diagnoses including diabetes mellitus, and age related physical debility. Resident #6's clinical record lacked documented evidence of non-discrimination form with the information to contact the State Agency to file a complaint. Resident #4 Resident #4 was admitted to the facility on 01/30/23, with diagnoses including dementia, hypertension, stress incontinence and age-related debility. Resident #4's clinical record lacked documented evidence of non-discrimination form with the information to contact the State Agency to file a complaint. On 01/30/23 at 2:27 PM, the Resisdent Care Coordinator verbalized the facility created a new non-discrimination form with the State Agency contact information for the facility's admission			

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	packet and conducted a 100% chart review to ensure all residents were notified and signed the new form. The RCC verbalized the aforementioned residents did not have the new non-discrimination form in their clinical record. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 1 Scope: 3			
1540 SS= E	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 document review, personnel file review and interview, the facility failed to ensure all employees received cultural competency training within 30 business days of their date of hire for 4 of 8 sampled employees. (Employee #1, #2, #4 and #5). Findings include: The facility's Plan of Correction (POC) dated 05/24/23, documented all staff would be in compliance by 04/06/23 and any new staff would meet the guidelines through online training through an approved trainer. Employee #1 Employee #1 was hired as a Medication Technician with a start date of 12/29/20. Employee #1's personnel file documented cultural competency training dated 05/15/23, more than five weeks after	1540	1. We had asked all employee to complete the cultural competency requirement by 5/30, in the facility, however failed to correct that date in the POC. All current employees have a cultural competency education. 2. Per the last survey and surveyors, all new employees are required to complete a cultural competency within 30 days of hire. At time of hiring, we are setting up the staff with an online training to complete this requirement within 30 days. Staff understand that this must be done per regulation. 3. HR and staffing education coordinator will be keeping an audit on all employees to ensure they are meeting proper education requirements in the appropriate and required time frame. 4. HR/Employee Trainer 5. 5/30/23	05/30/2023

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	the POC compliance date. Employee #2 Employee #2 was hired as a Caregiver with a start date of 03/15/21. Employee #2's personnel file documented cultural competency training dated 05/30/23, more than seven weeks after the POC compliance date. Employee #4 Employee #4 was hired as a Caregiver with a start date of 06/05/20. Employee #4's personnel file documented cultural competency training dated 05/31/23, more than seven weeks after the POC compliance date. Employee #5 was hired as a Caregiver with a start date of 03/21/22. Employee #5's personnel file documented cultural competency training dated 05/31/23, more than seven weeks after the POC compliance date. On 06/01/23 at 3:00 PM, the Human Resources/Front Office Assistant confirmed the cultural competency training dates for Employee #1, #2, #4, and #5. On 06/01/23 at 3:10 PM, the Administrator verbalized employees take the cultural competency training online and the aforementioned employees completed the training after the 04/06/23 compliance date in the facility's Plan of Correction dated 05/24/23. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 2			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause	1700	1. The resident was admitted to the facility with the incorrect placement determination form box marked. The resident is not an elopement risk and does not require wander control systems. Her physician was contacted and was educated on the different options that can be choosen and the physician updated the placement form. 2. The placement determination form will be more closely monitored prior to admission that the correct placement has been determined. 3. The Care Coordinator will be reviewing prior to admission. 4. Care Coordinator 5. 06/06/2023	06/06/2023

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	a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review, document review and interview, the Administrator failed to ensure a Standard Physician Assessment and Placement Determination was appropriately completed for 1 of 8 sampled residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 01/30/23, with diagnoses including dementia, hypertension, stress incontinence			

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	and age-related debility. Resident #4's clinical record contained a Standard Physician Assessment and Placement Determination dated 01/17/23 indicating the resident was appropriate for a facility providing care to a person with Alzheimer's disease or related dementia and a staffing ratio requirement of no more than six residents to one staff member. Resident #4 was residing in the assisted Living portion of the facility and not in the locked memory care unit. On 01/30/23 at 2:27 PM, the Resident Care Coordinator confirmed Resident #4's level of dementia did not require the resident to be in the facility's memory care unit and the Standard Physician Assessment and Placement Determination had not been completed appropriately for Resident #4. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 1			
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator.	0874	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023

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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, document review, and interview, the Administrator failed to ensure an Ultimate User Agreement was dated upon resident admission for 1 of 8 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 03/11/23 with diagnoses including history of cerebral vascular accident, hemiparesis affecting left side, limited mobility, hypertension and seizures. Resident #7's Ultimate User Agreement was signed by the resident, however the document was not dated. On 06/01/23 at 2:18 PM, the Resident Care Coordinator (RCC) verbalized all Ultimate User Agreements were to be signed and dated upon resident admission to be a valid document. The RCC confirmed Resident #7 did not have a completed Ultimate User Agreement. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 2	0876	1. The resident did not sign the ultimate user agreement; we went back to the resident and asked her to sign the form. 2. Moving forward after the admission packet has been signed, a second set of eyes will look over the packet after it has been signed. 3. By ensuring that the old document has been removed from the packet, then it should be fixed 4. HR/Care Coordinator/Administrator 5. 6/1/2023	06/01/2023

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0878 SS= D	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-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.	0878	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.	0885	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
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 record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for a 1 of 8 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/15/23, with diagnoses including depression with suicidal ideation, suicidal attempt with self-cutting, neurocognitive disorder, anxiety and failure to thrive. On 06/01/23 at 10:34 AM, the resident's physician order dated 04/27/23 and the resident's May 2023 MAR	0895	1. During the time of survey, we had a Medication Tech working that specific shift that was not understanding the process of passing and charting. She has since been termed since finding these issues at time of survey. We have since hired a new Med Tech Supervisor that is re-training our med tech's and creating new habits for passing meds and doing a daily audit of MARS. 2. Moving forward we have a shift to shift MAR documentation review that happens at every shift between the Med Tech getting off and the med tech getting on shift. They review to ensure that everything has been documented and charted properly. It esnures that the med techs are being held accountable for their med passes. 3. By enforcing the shift to shift review between med tech's and having the med tech supervisor review the documentation we can ensure that charting in completion will take place. 4. Care Coordinator/Administrator/ Med Tech supervisor 5. 07/25/23	07/25/2023

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	documented the following medication was not initialed as administered: -Metformin 500 milligram (mg) tablet, take two tablets by mouth every evening for diabetes with dinner, was not initaled as administered on 05/26/23. -Melatonin 3 mg tablet, take one tablet by mouth at bedtime for insomnia, was not initialed as administered from 05/25/23 to 05/28/23. -Loratadine 10mg tablet, tabke one tablet by mouth at bedtime for itching and allergies, was not initialed as administered from 05/25/23 to 05/28/23 and 05/31/23. -Tamsulosin 0.4mg capsule, take one capsule by mouth at bedtime, was not initialed as administered from 05/25/23 to 05/28/23. -Apixaban 5mg tablet, take one half tablet by mouth twice a day for stroke prevention, was not initialed as administered on 05/26/23 for PM dosage. -Metropolol 100mg tablet, take one tablet by mouth twice a day for heart rate control, was not initial as administered on 05/27/23 for both AM and PM dosage. -Gabapentin 400mg tablet, take one tablet by mouth twice a day, was not initialed as administered on 05/26/23 for the PM dosage. -Docusate 50mg capsule, take two capsules by mouth daily, was not initialed as administered on 05/25/23. -Petrolaium ointment, apply liberally to affected areas twice a day for dry skin of legs and arms, was not initialed as administered on 05/25/23 to 05/28/23 and 05/31/23 for PM dosage. -Clonazepam 0.5mg tablet, take one tablet by mouth every evening, was not initialed as administed on 05/26/23 and 05/31/23. -Capsaician cream 0.025%, apply thin layer to affected area four time a day for nerve pain left lower extremities, was not initialed as administered 05/25/23 to 05/28/23, for the PM dosage. On 06/01/23 at 02:01 PM, the Medication Technician (MT) expressed being unsure if the medications were administered to the resident for the dates not initialed on the MAR. The MT confirmed the MAR needed to be signed off after administration of a medication to ensure medications were not			

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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
	administred duplicate times, and to follow physican orders. Severity: 2 Scope: 1			
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure 1 of 8 sampled residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 01/30/23, with diagnosis including dementia, hypertension, stress incontinence and age-related debility. Resident #4's clinical record lacked documented evidence of two step TB testing completed upon admission. On 06/01/23 at 2:07 PM, the Resident Care Coordinator confirmed Resident #4 did not have a two step TB test and explained TB tests were required for all residents upon admission and annually thereafter. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 1	0936	1. Resident did receive a tb test prior to admission however the tb result was misfiled. It was filed correctly, on 6/2/2023. 2. At time of admission facility will ensure all documents are filed in the appropriate places. 3. An audit will be done at time of admission to ensure all documents are there. 4. Care Coordinator 5. 6/2/2023	06/02/2023
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after	0938	1. The ADL was done at time of admission however it wasn't dated. Resident dated it at time of finding. 2. An audit will be done after admission to ensure all dates have been done. 3. A second set of eyes to look at the chart will be assist with a checks and balances	06/01/2023

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		A. BUILDING _____ B. WING _____	**06/01/2023**

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	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 clinical record review and interview, the facility failed to ensure an initial Activities of Daily Living (ADL) assessment was completed at or prior to admission for 1 of 8 residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 03/11/23 with diagnoses including history of cerebral vascular accident, hemiparesis affecting left side, limited mobility, hypertension and seizures. Resident #7's clinical record lacked documented evidence an initial ADL assessment was completed at admission. On 06/01/23 at 2:18 PM, the Resident Care Coordinator (RCC) confirmed the ADL assessments for Resident #7 was not completed at admission. The RCC explained ADL assessments were to be completed at admission. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 1		system. 4. Care Coordinator/Administrator 5/ 6/1/23	

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0994 SS= E	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, interview, and document review the facility failed to ensure resident safety by securing dangerous items for residents in a secured unit (Room #37 and #40). Findings include: On 06/01/23 between 8:33 AM and 8:45 AM, during a tour of the secured unit accompanied by the Caregiver, the following resident rooms were found to contain unsecured, dangerous items: Room #40- one sharp medal cross laying on bed side table Room #37- one pencil hidden on a picture frame on top of a clothing dresser Room #37- one metal fork sitting on a bed side table Room #37- one light green crayon inside the top drawer of a clothing dresser On 06/01/23 at 8:45 AM, the Caregiver confirmed the hazardous items including sharp metal objects, pencils, forks, and crayons should not be located in the rooms, and could be very dangerous for the resident. The facility policy titled "Environmental Safety," dated 07/19/18, documented personal items perceived as potentially hazardous would not be stored or maintained at the Community site. Craft items including scissors were only used with staff supervision. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 3	0994	1. The items found were removed including the cross; which was overlooked due to religious preferences. 2. A room audit checklist has been created for the caregivers to do daily, along with the supervisor on call for the week to also do. Its done daily. The audit is in a binder on memory care. 3. By checking the rooms daily and ensuring things are locked up issues should not arise. Each caregiver has been trained on safety and will sign off that they have been trained on the audit. 4. Care Coordinator, All supervisors, Administrator 5. 7/21/23	07/21/2023

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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, interview and document review, the facility failed to ensure toxic items were secured in 2 of 9 resident rooms for residents in a secured unit (Room #38 and #40). Findings include: On 06/01/23 at 8:33 AM, during the facility tour with the memory care Caregiver, the following toxic substances were observed in resident rooms: Room #38 - one opened .25 ounce tube of mascara located on top of a clothing dresser Room #40 - one opened 15 ounce bottle of body wash On 06/01/23 at 8:45 AM, the Caregiver was present at each discovery and verbalized the items should not be stored unsecured in resident rooms. The facility policy titled, "Memory Care Environmental Guidelines," last updated 03/30/23, documented potentially hazardous or toxic materials were to be stored in a locked area not accessible by residents. This was a repeat deficiency from the 02/07/23 annual survey. Severity: 2 Scope: 3	0999	1. The items found were removed including the cross; which was overlooked due to religious preferences. 2. A room audit checklist has been created for the caregivers to do daily, along with the supervisor on call for the week to also do. Its done daily. The audit is in a binder on memory care. 3. By checking the rooms daily and ensuring things are locked up issues should not arise. Each caregiver has been trained on safety and will sign off that they have been trained on the audit. 4. Care Coordinator, All supervisors, Administrator 5. 7/21/23	07/21/2023
1010 SS= D	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	1010	1. Resident had an appropriate physician assessment and placement form for admission. However after working with the surveyor we understand that he is not appropriate for our building due to physician notes in another H&P. Resident is being transferred out of the building. Transfer date is expected on 7/25/23. Family on board. Should the transfer date be pushed to transport issues HCQC will be notified. 2. Moving forward if any physician reports are included we will double check diagnosis'	07/25/2023

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	endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on clinical record review, document review and interview, the facility failed to obtain an endorsement for Mental Illness (MI) and admitted and retained a resident with a MI diagnosis for 1 of 8 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/15/23, with diagnoses including depression with suicidal ideation, suicidal attempt with self-cutting, neurocognitive disorder, anxiety and failure to thrive. A History and Physical dated 05/16/23, documented Resident #2 had diagnoses including depression with suicidal ideation, suicidal attempt with self-cutting, neurocognitive disorder, anxiety and failure to thrive. A physician's order dated 04/27/23, documented duloxetine 90 milligrams (mg), take one capsule by mouth daily for anxiety, clonezapam 0.5 mg, take one tablet by mouth every evening for anxiety and sertraline HCL 50 mg, take one tablet by mouth daily for depression. The facility lacked an MI endorsement to admit and retain residents with a MI diagnosis. On 06/01/23 at 2:19 PM, the Resident Care Coordinator confirmed the facility was not endorsed for MI and verbalized Resident #2 had diagnoses including depression with suicidal ideation, suicidal attempt with self-cutting, neurocognitive disorder, anxiety and failure to thrive. Severity: 2 Scope: 1		as well as any old issues. 3. We understand that we are only to admit with the appropriate diagnosis and did not catch the particular psych issues. 4. Care Coordinator/Administrator 5. 7/25/23	

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1035 SS= D	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: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family.	1035	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023
1036 SS= D	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.	1036	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023

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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 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).	1037	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023

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1310 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. (Added to NRS by 2019, 1333, effective January 1, 2020)	1310	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 6W3F11.	06/01/2023