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 _____	**03/11/2024**

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 State Licensure annual grading survey and complaint investigations completed in your facility on 03/11/2024, 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 and disabled persons and/or persons with Alzheimer's disease, 45 Category II and 12 Category II (Alzheimer's) residents. The census at the time of the survey was 39 10 resident files and 12 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. There was one complaint investigated. Complaint #NV00070050 with the allegation an employee was found in bed with a resident was substantiated (See Tag Y0556 and Y0590). The following allegation could not be substantiated due to a lack of evidence: Allegation #1: employee training certificates were falsified. Allegation #2: an employee was heard yelling at residents. Allegation #3: an employee ripped a doll away from a resident's arm. Allegation #4: an employee took money from a resident. Allegation #5: some residents do not have medication administration records (MAR). Allegation #6: no snacks or water are offered to residents. Allegation #7: residents in memory care unit	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: SAMANTHA R. MITCHELL | Title: Administrator | Date: 09/26/2024

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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	sit in recliner chairs all day. Allegation #8: a resident was raped by another resident and was not reported. Allegation #9: alcohol was smuggled into facility by a resident's family member. Allegation #10: residents are being double briefed. The investigation into the allegations included: Observations of residents in the memory care unit, of staff interactions with residents, and of snacks and beverages offered to residents. Interviews were conducted with the Administrator, the Administrator in Training, the Business Office Manager, a caregiver, and three residents. Reviewed 39 resident records, to include MARs, and incident reports, and 12 employee records, to include training certificates, and termination documentation. 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:			
0895 SS= B	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine	0895	1. Correct medication orders were updated in the MAR and med techs will be re-educated on medication policy/procedure of missed/refused medication doses to avoid missing initials on the MAR. 2. Moving forward, dayshift med tech staff, Administrator, and pharmacy will be doing monthly audits with medication audit checklist to ensure medications are correctly labeled and match the physician order and medication administration record. Re-education of missed/refused medication policy/procedure will be completed by 7/25/2024. 3. Administrator will be assisting with medication audits and ensuring a medication checklist is being followed.	07/25/2024

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	schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 3 of 10 sampled residents (Resident #3, #7, and #6). Finding include: Resident #3 Resident #3 was admitted to the facility on 01/24/2024, with diagnoses including dementia, restless leg syndrome, and hypertension. On 03/11/2024 at 12:04 PM, the resident's physician order dated 01/23/2024 and the resident's March 2024 MAR documented the following medication were not initialed as administered: -carvedilol 3.125 milligram (mg) tablet, take one tablet by mouth twice daily. -gabapentin 300 mg capsule, take two capsules by mouth twice daily. -melatonin 5 mg tablet, chew two tablets by mouth at bedtime for insomnia. -ropinirole 3 mg tablet, take one tablet by mouth at bedtime. On 03/11/2024 at 12:05 PM, the Medication Technician (MT) expressed being unsure if the medications, not initialed on the MAR, were administered to the resident for the evening of 03/10/2024. The MT explained there was no reason to ever have blanks in the MAR. The MT confirmed the MAR needed to be signed off after administration of a medication to ensure medications were not administered duplicate times, and to follow physician orders. Resident #7 Resident #7 was admitted to the facility on 04/15/2021, with diagnoses including low vision, mild dementia, atrial fibrillation, chronic obstructive pulmonary disease, prostate cancer, and hypertension. On 03/11/2024, during a medication review, the following medications were available in the		Individual Med tech in-service regarding missed medications policy/procedure completed by 7/25/2024. 4. Med Tech, Administrator 5. Completion date for re-education of the missed/refused dose policy will be 7/25/2024	

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	medication cart for Resident #7: -milk of magnesium hydroxide, take 30 milliliters (ml) by mouth one time a day if no bowel movement for 2 days -nitroglycerin 0.4 mg tablet, dissolve one tablet under the tongue as needed for chest pain, may repeat after five minutes up to three doses if systolic blood pressure is greater than 90 millimeters mercury (MMHG) The March 2024 MAR for Resident #7 did not include milk of magnesium and nitroglycerin. A Physician's Order for Resident #7, dated 11/02/2022, documented the following order: -milk of magnesium hydroxide, take 30 milliliters (ml) by mouth one time a day if no bowel movement for 2 days - nitroglycerin 0.4 mg tablet, dissolve one tablet under the tongue as needed for chest pain, may repeat after five minutes up to three doses if systolic blood pressure is greater than 90 millimeters mercury (MMHG) On 03/11/2024 at 11:42 AM, the MT confirmed the MAR was not up to date for the Resident #7. The MT verbalized the MAR should be accurate and include the most current medication orders. Resident #6 Resident #6 was admitted to the facility on 01/03/24, with diagnoses including anemia, chronic obstructive pulmonary disease, and congestive heart failure. Resident #6's medication container for the following medication documented: - albuterol sulfate HFA 90 mcg. Inhale two puffs by mouth every six hours as needed for shortness of breath. Resident #6's March 2024 MAR documented the following: - albuterol sulfate HFA 90 mcg. Inhale two puffs by mouth every four hours as needed for wheezing. Resident #6's physician's order dated 02/15/24, documented the following: - albuterol sulfate HFA 90 mcg. Inhale two puffs by mouth every six hours as needed for shortness of breath. On 03/11/24 at 3:20 PM, the Administrator confirmed Resident #6's MAR for the albuterol sulfate did not match the current physician's order dated 02/15/24. Severity: 1 Scope: 2			

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure over-the-counter medications were labeled with the resident's name and the physician's name for 1 of 10 residents (Resident #3). Finding include: Resident #3 Resident #3 was admitted to the facility on 01/24/2024, with diagnoses including dementia, restless leg syndrome, and hypertension. During Resident #3's medication review, a bottle of preserVision capsule areds was available in the medication cart; however, lacked the physician's name on the bottle. A physician's order dated 01/23/2024, documented preserVision areds 250 mg capsules, take one tablet oral daily for eye health. Resident #3's February Medication Administration Record (MAR) documented preserVision areds 250 mg capsules, take one tablet oral daily for eye health. On 03/11/2024 at 12:04 PM, the Medication Technician confirmed the bottle of preserVision capsule lacked the physician's name. The Medication Technician explained all over the counter medications were required to have the physician's name and the resident's name labeled on the bottle. Severity: 2 Scope: 1	0923	1. The over-the-counter medication was updated on the label with the resident's name and physician's name 2. Moving forward, dayshift med tech staff, Administrator, and pharmacy will be doing monthly audits with medication audit checklist to ensure medications are correctly labeled and match the physician order and medication administration record. 3. Administrator will be assisting with medication audits and ensuring a medication checklist is being followed. 4. Med Tech, Administrator 5. 9/11/2024	09/11/2024

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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 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 01/03/2024, with diagnoses including anemia, chronic obstructive pulmonary disease, and congestive heart failure. Resident #6's clinical record contained a one TB test given on 09/29/2023 and read negative on 10/01/2023. The clinical record lacked a second step TB test. On 03/11/2024 at 11:56 AM, the Administrator in Training (AIT) verbalized a two step TB was required to be completed upon admission to the facility. The AIT confirmed Resident #6 did not have a second step TB test completed. Severity: 2 Scope: 1	0936	1. A 2-step TB test was completed for resident #6 after completion of the survey. 2.Facility will ensure that an initial 2-step TB or QuantiFERON is completed prior to admission showing that the health information is in compliance. A health information checklist is provided in the admissions packet to be completed prior to admission 3. A health information checklist is provided in the admissions packet and the Administrator and care coordinator will be reviewing the health information before a resident is admitted ensuring the information is completed and in compliance. 4. Care Coordinator, Administrator 5. 9/11/2024	09/11/2024
0938 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 facility and retained for at least 5 years after he or she permanently leaves the facility.	0938	1. ADL assessments were updated for residents #2, #4, #9 2. Facility is working to ensure that the annual ADL assessments are meeting the guidelines. That is being done by collecting the due dates and entering the date in a database system which will	09/11/2024

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	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 and interview, the facility failed to ensure initial and annual Activities of Daily Living (ADL) assessments were completed timely for 3 of 10 sampled residents (Resident #2, #4, and #9). Findings include: Resident #2 Resident #2 was admitted to the facility on 10/25/2022, with a diagnosis of mild dementia. Resident #2's clinical record documented ADL assessment with an assessment date of 10/25/2022. The ADL assessment notated on the bottom of the form "updated 09/04/2023 - no changes other than hospice". The ADL assessment lacked documented evidence of a signature from the facility and the resident indicating the ADL assessment had been completed on 09/04/2023. Resident #4 Resident #4 was admitted to the facility on 06/16/2022, with diagnoses including dementia, acute tubular necrosis, and hypertension. Resident #4's clinical record documented ADL assessment with an assessment date of 02/17/2023. The ADL assessment notated on the bottom of the form "06/15/2023 - resident in on hospice, can still ambulate". The ADL assessment lacked documented evidence of a signature from the facility and the resident indicating the		allow us to create monthly reports. All annual ADL assessments will be done on a new assessment sheet each year. 3. Having compiled this information will help staff run timely and accurate reports showing us who is due for the next month. 4. Care Coordinator, Administrator 5. 9/11/2024	

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	ADL assessment had been completed on 06/15/2023. On 03/11/2024 at 11:51 AM, the Administrator in Training (AIT) verbalized an ADL assessment should be completed upon admission and annually. The AIT explained the expectation was the ADL assessment would be dated and signed by the resident and the facility. The AIT confirmed the ADL assessment dated 09/04/2023 for Resident #2, and 06/15/2023 for Resident #4, lacked a signature from each resident and the facility the ADL assessment was completed. Resident #9 Resident #9 was admitted to the facility on 02/03/2023, with diagnoses including dementia, chronic obstructive pulmonary disease, and interstitial lung disease. Resident #9's clinical record documented an ADL assessment had been completed on 02/03/2023, however, lacked documented evidence an ADL assessment was completed for 2024. On 03/11/2024 at 2:04 PM, the AIT verbalized ADL assessments were required to be completed upon admission and annually thereafter. The AIT confirmed Resident #9 did not have an ADL assessment completed for 2024. Severity: 2 Scope: 2			

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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 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 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 10 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted on 03/01/2022, with diagnoses including bipolar disorder, dementia with behavioral disturbances, and post traumatic stress disorder (PTSD). A History and Physical dated 02/03/2023, documented Resident #10 had a diagnosis of bipolar disorder and PTSD. The facility lacked an MI endorsement to admit and retain residents with MI. On 03/11/2024 at 11:50 AM, the Administrator in Training confirmed the facility was not endorsed for MI and Resident #10 had diagnosis of bipolar disorder and PTSD. Severity: 2 Scope: 1	1010	1. It was identified that the resident has a mental illness listed in her diagnosis. 2. Facility acknowledged this diagnosis. Resident has a public guardian and must have an appropriate hearing and relocation approval prior to the resident moving from our facility. Facility is having a meeting with the guardian on 7/17/2024 to talk about a relocation plan for the resident. Currently facility is looking for a higher level of care. Resident was admitted to higher level of care on 8/23/2024, no longer a resident of Mason Valley Residence. 3. Facility will be diligent in reviewing diagnosis of residents prior to admissions. 4. Care Coordinator/Administrator 5. 08/23/2024	09/23/2024
1700 SS= E	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	1700	1. At the time of the survey, it was found that annual placement forms were not updated by the due date. 2. Facility is working to ensure that the annual placement forms are meeting the guidelines. That is being done by collecting the due dates and entering the date in a database system which will allow us to create monthly reports.	07/15/2024

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	health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the		3. Having compiled this information will help staff run timely and accurate reports showing us who is due for the next month. 4. Care Coordinator, Administrator	

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	Administrator failed to ensure a standard placement determination was completed annually and timely by a provider for residents with a diagnosis of dementia, not residing in memory care for 3 of 10 residents (Resident #2, #1, and #7). Findings include: Resident #2 Resident #2 was admitted to the facility on 10/25/22, with a diagnosis of mild dementia. Resident #2's clinical record documented an initial Standard Physician Assessment and Placement Determination dated 10/24/2022. Resident #2's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination was completed in 2023. On 03/11/24 at 11:51 AM, the Administrator in Training (AIT) verbalized Resident #2 had a diagnosis of dementia and did not reside in memory care. The AIT confirmed Resident #2 did not have a Standard Physician Assessment and Placement Determination completed for 2023. Resident #1 Resident #1 was admitted to the facility on 01/30/2023, with diagnoses including dementia, hypertension, and degenerative arthritis right shoulder. Resident #1's clinical record documented an initial Standard Physician Assessment and Placement Determination dated 06/06/2023. On 03/11/2024 at 11:55 AM, the AIT verbalized Resident #1 had a diagnosis of dementia and did not reside in memory care. The AIT confirmed Resident #1's Standard Physician Assessment and Placement Determination had not been completed upon admission. Resident #7 Resident #7 was admitted to the facility on 04/15/2021, with diagnoses including low vision, mild dementia, atrial fibrillation, chronic obstructive pulmonary disease, prostate cancer, and hypertension. Resident #7's clinical record included a physician placement determination dated 04/09/2021. The clinical record lacked documented evidence a physician placement determination had been completed in 2022 and 2023. On 03/11/2024 at 2:00 PM, the AIT confirmed a			

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	physician placement determination had not been completed in 2022 and 2023 for Resident #7. The AIT confirmed physician placement determinations were required to be completed annually for residents with a diagnosis of dementia. Severity: 2 Scope: 2			
0321 SS= E	Bedroom Doors - Single Motion Locks - NAC 449.220 Bedroom doors. (NRS 449.0302) 2. A bedroom door must not be equipped with a deadbolt lock or chain stop unless the door opens directly to the outside of the facility. The doors of a bedroom and the doors of the closets in the bedroom may be equipped with locks for use by residents if: (a) The doors may be unlocked with a single motion from inside the bedroom or closet without the use of a key; and (b) The doors of the bedroom may be unlocked from outside the room and the keys are readily available at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure resident room doors were equipped with single motion locks. Findings include: On 03/11/2024 at 10:08 AM, all resident room doors in the memory care unit contained double-motion dial locks. On 03/11/2024 at 10:08 AM, the Maintenance Director confirmed two motions were required to open the doors if they were locked. Severity: 2 Scope: 2	0321	1. Single motion locks were purchased on 7/15/2024 to replace the current double motion locks. 2. New single motion locks delivered to the facility on 7/17/2024, all single motion locks were installed by 7/26/2024 3. Now aware of the regulation, single motion locks will be purchased for the memory care unit if necessary to replace again in the future. 4. Maintenance Director 5. 07/26/204	07/26/2024

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0451 SS= F	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure first aid kits contained CPR shields. Findings include: On 03/11/2024 at 10:44 AM, the first aid kits throughout the facility lacked CPR shields. On 03/11/2024 at 10:44 AM, the Administrator in Training (AIT) confirmed the facility first aid kits lacked CPR shields. The AIT verbalized CPR shields had been ordered; however, was unable to provide documented evidence the CPR shields had been ordered. Severity: 2 Scope: 3	0451	1. Facility bought kits that did have CPR masks at the time. However, the masks had been used and the facility failed to re-order masks. CPR masks were ordered at the time of discovery during the survey. Masks arrived and were in facility by 3/20/24. 2. A monthly audit will be conducted to ensure the kits are fully complete. 3. A first aid/CPR checklist for supplies will be followed. 4. Administrator/Managers 5. 9/20/2024	09/20/2024

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0556 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) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on record review, interview and document review, the facility failed to ensure a Serious Occurrence Report was reported to the office of the Aging and Disability Services Division (ADSD) of the Department of Health and Human Services. Findings include: Employee #14 Employee #14 was hired on 11/06/2023 as a caregiver. An Employee Disciplinary Action Form dated 11/15/2023, documented Employee #14 was found asleep in a resident's bed with the resident. Employee #14 was unresponsive and had to be woken up. Employee #14 smelled of alcohol and was sent home. Employee #14 was terminated due to inappropriate behavior with a resident and possible intoxication on the job. The Employee Disciplinary Action Form lacked the name of the resident or a resident's room number. On 03/11/2024 at 4:00 PM, the Administrator in Training confirmed a Serious Occurrence Report had not been completed or reported to ADSD. The Administrator in Training confirmed a report should have been completed and reported to ADSD per the regulation. The facility policy titled, "Abuse, Fraud, and Wrongdoing," undated, documented all appropriate parties would be notified of an outcome of an investigation and incidents related to abuse and exploitation would be reported in compliance with State regulatory requirements. Severity: 2 Scope: 1	0556	1. We understand that a Serious Occurrence report will be completed in the appropriate timeline required and any abuse will be reported appropriately 2. Moving forward policy regarding abuse, fraud, and wrongdoings will be followed and all appropriate parties will be notified. When disciplinary action forms are completed that involve residents, the resident room number will be added instead of a resident name due to HIPAA. Human Resources will be monitoring any disciplinary actions that involve residents/staff to be reported to the Administrator. 3. All abuse reporting will be monitored by the Administrator to make sure the proper procedures are taking place. 4. Human Resources, Administrator 5. 7/16/2024	07/16/2024

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0590 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and 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, interview and document review, the facility failed to ensure a caregiver was not found asleep in a resident's bed with the resident. Findings include: Employee #14 Employee #14 was hired on 11/06/2023 as a caregiver. An Employee Disciplinary Action Form dated 11/15/2023, documented Employee #14 was found asleep in a resident's bed with the resident. Employee #14 was unresponsive and had to be woken up. Employee #14 smelled of alcohol and was sent home. Employee #14 was terminated due to inappropriate behavior with a resident and possible intoxication on the job. The Employee Disciplinary Action Form lacked the name of the resident or a resident's room number. On 03/11/2024 at 4:00 PM, the Administrator in Training verbalized not remembering the incident and could not remember the name of the resident involved. On 03/11/2024 at 4:01 PM, the Administrator in Training confirmed Employee #14 had been terminated due to having been found asleep in a resident's room. The facility policy titled, "Dignity," undated, documented staff were to be respectful and courteous in all interactions with residents. Severity: 2 Scope: 1 Complaint #NV00060050	0590	1. Administrator understands that it is their duty to ensure that residents are not abused, neglected or exploited by any member of the facility or anyone outside the facility. An elder abuse in-service will be held with current staff members to re-educate them on elder abuse, in-service will be held on 10/3/2024. 2. Moving forward, a new employee orientation with Human Resources will be held before new staff members start with hands-on care to ensure they are well versed in what elder abuse is and what our policies and procedures are regarding the subject. 3. This practice will be monitored by creating a new hire orientation checklist. This checklist will be followed by Human resources and monitored by the administrator. 4. HR, Administrator 5. 10/3/2024	10/03/2024
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be	0690	1. It was identified during the survey that a resident room had oxygen tanks not secured. It was corrected at the time of finding.	07/15/2024

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	permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured in 1 of 4 rooms with residents using oxygen. Findings include: On 03/11/2024 at 10:31 AM, Room 8 contained three size B oxygen cylinders sitting directly on the floor. On 03/11/2024 at 10:31 AM, the Maintenance Director confirmed the oxygen tanks were not secured and verbalized oxygen tanks should be kept secured. Severity: 2 Scope: 1		2. Facility has created an acknowledgment and policy for each resident that requires oxygen, must review and understand the policy and then sign. Printed signs stating "full" and "empty" will be hung above racks. This will ensure that all staff, residents and family understand where to store bottles. 3. Review oxygen tanks will be added to the walking rounds shift to shift report. It will require caregivers to check on oxygen tanks twice a day. Also, the management will do a monthly audit. 4. Administrator, Managers, caregivers 5. 7/15/24	

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0791 SS= D	Diabetes - Disposal of Sharps - NAC 449.2726 - Residents having diabetes 3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that: (b) Syringes and needles are disposed of appropriately in a sharps container which is stored in a safe place; and Inspector Comments: Based on observation and interview, the facility failed to provide a sharps container to a resident who self-administered insulin. Findings include: On 03/11/2024 at 10:29 AM, the resident in Room 4 had a small sharps container in the room; however, the resident had been putting used lancets in a small bowl on the kitchen counter. On 03/11/2024 at 2:00 PM, the resident verbalized the sharps container was full and the the resident had not turned in the sharps container to facility staff. On 03/11/2024 at 10:29 AM, the Maintenance Director confirmed the used lancets were not disposed of into the sharps container. Severity: 2 Scope: 1	0791	1. A sharps container was not located for a resident at the time of survey. Sharps container was ordered, received and med techs are monitoring the container. 2. A policy and acknowledgement were given to the resident to understand the requirements. 3. A monthly audit will be conducted to ensure the container is available, clean and located in the resident's room. 4. Administrator, Care Coordinator, med techs 5. 7/15/2024	07/15/2024
0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (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 a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an annual general physical examination was completed timely for 3 of 10 sampled residents (Resident #4, #1 and	0859	1. At the time of the survey it was found that annual physicals were conducted, however not by the due date. 2. Facility is working with physician staff to ensure that the annual physicals are meeting the guidelines. That is being done by collecting the due dates and entering the date in a database system which will allow us to create monthly reports. 3. Having compiled this information will help staff run timely and accurate reports showing us who is due for the next month. 4. Care Coordinator, Administrator 5. 7/15/24	07/15/2024

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	#7). Findings include: Resident #4 Resident #4 was admitted to the facility on 06/16/2022, with diagnoses including dementia, acute tubuler necrosis, and hypertension. Resident #4's clinical record documented a general physical examination was completed on 03/01/2023; however, lacked documented evidence a general physical exam was completed in 2024. On 03/11/2024 at 3:05 PM, the Administrator in Training (AIT) provided a Plan of Care from hospice. The Administrator confirmed the facility did not have a current history and physical on file for Resident #4. Resident #1 Resident #1 was admitted to the facility on 01/30/2023, with diagnoses including dementia, hypertension, and degenerative arthritis right shoulder. Resident #1's clinical record documented an initial physical exam completed on 01/17/2023, and an annual completed on 02/03/2024. The 2024 physical exam was completed 17 days late. On 03/11/2024 at 2:03 PM, the AIT explained annual physicals were to be completed on or before the previous physical date. The AIT confirmed Resident #1's 2024 physical was late. Resident #7 Resident #7 was admitted to the facility on 04/15/2021, with diagnoses including low vision, mild dementia, atrial fibrillation, chronic obstructive pulmonary disease, prostate cancer, and hypertension. Resident #7's clinical record documented an initial physical exam completed on 03/31/2021, and an annual 11/04/2022. Resident #7's clinical record lacked documented evidence an annual physical exam was completed for 2023. On 03/11/2024 at 2:03 PM, the AIT explained annual physicals were to be completed on or before the previous physical date. The AIT confirmed Resident #7's annual physical for 2023 was not completed. Severity: 2 Scope: 2			
0874 SS= C	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver	0874	1. The prior medication administration reports were not signed within the 72-hour date range.	07/15/2024

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	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, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, was reviewed and initialed by the Administrator within 72 hours for 7 of 10 sampled residents residing in the facility for longer than six months and requiring a six month medication profile review (Resident #2, #4, #10, #1, #5, #7 and #9). Findings include: Resident #2 Resident #2 was admitted to the facility on 10/25/2022, with a diagnosis of mild dementia. Resident #2's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the Administrator on 01/03/2024, after the 72 hour requirement. Resident #4 Resident #4 was admitted to the facility on 06/16/2022, with diagnoses including dementia, acute tubular necrosis, and hypertension. Resident #4's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the Administrator on 01/03/24, after the 72 hour requirement. Resident #10 Resident #10 was admitted on 03/01/2022, with diagnoses including bipolar disorder, dementia with behavioral disturbances, and post traumatic stress disorder. Resident #10's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the		2. Administrator understands that reports must be reviewed and signed within 72 hours to ensure compliance. 3. Moving forward, the Administrator will ensure that all reports received from the pharmacy are reviewed and dated immediately. 4. Administrator/Care Coordinator 5. 7/15/2024	

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	Administrator on 01/03/2024, after the 72 hour requirement. Resident #1 Resident #1 was admitted to the facility on 01/30/23, with diagnoses including dementia, hypertension, and degenerative arthritis right shoulder. Resident #1's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the Administrator on 01/03/2024, after the 72 hour requirement. Resident #5 Resident #5 was admitted to the facility on 06/07/23, with diagnoses including acute respiratory failure, dementia, and hypertension. Resident #5's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the Administrator on 01/03/2024, after the 72 hour requirement. Resident #7 Resident #7 was admitted to the facility on 04/15/2021, with diagnoses including low vision, mild dementia, atrial fibrillation, chronic obstructive pulmonary disease, prostate cancer, and hypertension. Resident #7's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the Administrator on 01/03/2024, after the 72 hour requirement. Resident #9 Resident #9 was admitted to the facility on 02/03/2023, with diagnoses including dementia, chronic obstructive pulmonary disease, and interstitial lung disease. Resident #9's clinical record documented a six-month medication profile review dated 12/24/2023. The medication profile review was reviewed and dated by the Administrator on 01/03/2024, after the 72 hour requirement. On 03/11/2024 at 11:55 AM, the Administrator in Training (AIT) confirmed the pharmacy reviews completed 12/24/2023 were not signed within 72 hours of review. Severity: 1 Scope: 3			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication:	0878	1. Medication was not found in the building due to medications lack of use by Resident; the medication was overlooked and was not	09/11/2024

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	Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a		available in cart. The cream was refilled and replaced in the cart; the medication is refilled by a hospice agency. Medication technicians were reminded of the process of medication refills with hospice agencies. 2. Moving forward, dayshift med tech staff, Administrator, and pharmacy will be doing monthly audits with medication audit checklist to ensure medications are correctly labeled and match the physician order and medication administration record. 3. Administrator will be assisting with medication audits and ensuring a medication checklist is being followed. 4. Med Tech, Administrator 5. 9/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure medications were on-site to administer as prescribed for 1 of 10 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 04/15/2021, with diagnoses including low vision, mild dementia, atrial fibrillation, chronic obstructive pulmonary disease, prostate cancer, and hypertension. On 03/11/2024 at 11:42 AM, during a review of the resident's medications the following medication was not located. -mupirocin ointment 2%, apply liberal amount topically to left buttocks every six hours as needed for skin irritation. A physician's order dated 11/07/2023, mupirocin ointment 2%, apply liberal amount topically to left buttocks every six hours as needed for skin irritation. On 03/11/2024 at 11:45 AM, the Medication Technician confirmed the mupirocin ointment 2% was not on-site and available to administer to Resident #7. Severity: 2 Scope: 1			

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

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1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on 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 39 of 39 residents. Findings include: On 03/11/2024 in the morning, the facility was unable to provide documented evidence of a primary and secondary person responsible for the facility's infection control program. The Administrator in Training (AIT) verbalized beginning the required infection control training; however, was unable to provide documented evidence of completed training. On 03/11/24 in the morning, the AIT verbalized a primary or a secondary person, responsible for the required infection control and prevention training, had completed the training. Severity: 2 Scope: 3	1830	1. Infection control training had not been started. And facility acknowledged that this is a new requirement. 2. Facility has acknowledged 2 designees to spearhead this program. The Maintenance director will be the primary person and the lead housekeeper will be act as the secondary person. Staff understands that training must be done annually to ensure compliance. 3. After the initial training is complete the annual due date will be listed in the employee Human Resources audit; and will the training will be completed annually. 4. Maintenance, lead housekeeper, HR, Administrator 5. 10/3/2024	10/03/2024