Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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 an annual State Licensure survey conducted at your facility on 02/08/23. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for 60 Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, and/or persons with chronic illness, and provides assisted living services, Category II residents. The census at the time of the survey was 32. 10 resident files and 10 employee files were reviewed. The facility received a grade of C. 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. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: BENJAMIN KING Title: Administrator Date: 05/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
0172 SS= D	Health And Sanitation-Garbage - NAC 449.209 Health and sanitation. (NRS 449.0302) 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. Inspector Comments: Based on observation and interview, the facility failed to ensure a dumpster used to store garbage outside the facility was covered. Findings include: On 02/08/23 at 10:20 AM, the facility's dumpster lid was open and the Maintenance Director had to pull the dumpster away from the enclosure to close the lid. On 02/08/23 at 10:20 AM, the Maintenance Director verbalized the garbage removal vendor had emptied the dumpster in the morning and acknowledged the dumpster lid should be kept closed. Severity: 2 Scope: 1	0172	POC: 0172: Maintenance Director at facility immediately closed dumpster lid left open by the WM trash truck. Maintenance Director provided refresher training to staff 2/13/23 at monthly all-staff meeting. Going forward Maintenance Director, or ED if Maintenance Director not available, or staff when throwing away garbage, will monitor lid for closure throughout the day and as soon as possible and check dumpster lid when WM trash truck leaves premises.	02/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
0174 SS= D	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were free from garbage stored outside the dumpster. Findings Include: On 02/08/23 at 10:20 AM, two full plastic garbage bags were stored on the ground next to the dumpster. On 02/08/23 at 10:20 AM, the Maintenance Director acknowledged the garbage should have been placed inside the dumpster, preventing rodent access. Severity: 2 Scope: 1	0174	0174 POC: Maintenance Director at facility immediately picked up 2bags of trash that were dropped by the WM trash truck. Maintenance Director provided refresher training to staff 2/13/23 at monthly all-staff meeting. Going forward Maintenance Director, or ED if Maintenance Director not available, or staff when throwing away garbage, will monitor for trash on ground throughout the day and as soon as possible check for trash on ground when WM trash truck leaves premises.	02/08/2023
0250 SS= F	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation and interview, the facility failed to ensure dented cans were not stored with non-dented canned food inventory, refrigerated food was labeled and discarded by use-by date, and raw meat was not stored over other food items with the potential to affect the facility census of 30. Findings include: Dented Cans On 02/08/23 at 9:00 AM, in the dry storage room inventory of canned foods, there was the following dented cans: - two 112 ounce cans of vegetarian beans On 02/08/23 at 9:06 AM, the Director of Food Services confirmed the dented cans were stored in the dry food storage inventory of cans to be used for cooking for the residents. The Director of Food Services	0250	POC O250 On 2/08/23 day of survey meat was moved with the rest on lowest shelf. 2/08/23 the 2 dented cans were removed and protocol immediately established to remove and not use dented cans. On 2/08/23 all items were inspected, the aforementioned list of items were covered or in a container, labeled and dated, or removed. On03/24/23 the kitchen received an unannounced routine state inspection and the above items noted in the SOD 0250 had all been corrected. Kitchen Director will continue to monitor for above items.	02/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	verbalized they were marked to "use first," and confirmed not knowing the cans needed to be removed from inventory because they could cause botulism to the residents. Labeling and Discarding On 02/08/23 at 8:52 AM, in the walk-in refrigerator and dry storage area, the following foods were identified: - approximate one pound (lb) portion of ham was unlabeled and undated. - one pound cube of butter partially used was undated and not wrapped or in a container. - two lb plastic bag of Parmesan cheese partially filled was undated. - five lb plastic bag of cheddar cheese partially filled was undated. - one lb plastic container of ham pieces was unlabeled and undated. - two lb container of ham pieces was unlabeled and undated. - one pan partially filled with white cake was unlabeled and undated. - one gallon of Caesar dressing opened and undated with dressing dripping down the sides of the container. - one pan of chocolate chip cake was unlabeled and dated 01/31. - fifty lb bag of flour was left open on the shelf. On 02/08/23 at 8:59 AM, the Cook confirmed the aforementioned list of items should be covered or in a container, labeled and dated. The Cook verbalized the chocolate cake should have been discarded after three days on 02/04 if unused. Storage of Food On 02/08/23 at 8:52 AM, in the walk-in refrigerator, the wire shelf storage rack contained the following meat items stored on the second shelf over vegetables on the third shelf: - 10 lbs of sausage links - one five lb ham - two - three lb hams On 02/08/23 at 8:59 AM, the Cook confirmed the meat was stored over the vegetables and should be moved to a lower shelf so the meat juices could not potentially drip on the vegetables. Severity: 2 Scope: 3			
0620 SS= F	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	0620	0620 POC For Resident #7, #11, #12, #13, #14, #15, #16, #17, #18,and #19, all other current, future, or transferred residents requiring home health or hospice; the facility will follow NAC 449.2702 and will do placement determination by the physicians orders on all admissions, readmissions, and transfers	05/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 10 of 10 residents receiving skilled nursing services (Resident #7, #11, #12, #13, #14, #15, #16, #17, #18, and #19). Findings include: Resident #7 Resident #7 was admitted to the facility on 12/15/22, with a diagnosis of heart failure, unspecified. Resident #11 Resident #11 was admitted to the facility on 09/06/22, with a diagnosis of encephalopathy, unspecified. Resident #12 Resident #12 was admitted to the facility on 09/27/22, with a diagnosis of chronic atrial fibrillation, unspecified. Resident #13 Resident #13 was admitted to the facility on 04/01/21, with a diagnosis of adult failure to thrive. Resident #14 Resident #14 was admitted to the facility on 08/10/21, with a diagnosis of chronic obstructive pulmonary disease. Resident #15 Resident #15 was admitted to the facility on 03/15/17, with a diagnosis of chronic obstructive pulmonary disease. Resident #16 Resident #16 was admitted to the facility on 06/27/22, with a diagnosis of dementia, unspecified. Resident #17 Resident #17 was admitted to the facility on 09/27/22, with a diagnosis of dementia, unspecified. Resident #18 Resident #18 was admitted to the facility on 07/06/22, with an unknown diagnosis. Resident #19 Resident #19 was admitted to the facility on 04/30/22, with a diagnosis of metabolic encephalopathy. On 02/08/23 at 10:28 AM, the Wellness Director confirmed the facility had residents receiving skilled nursing care through home health and hospice agencies. The Wellness Director explained the Wellness Director was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The Wellness Director confirmed the facility had not submitted waivers to the State Agency to admit or retain residents receiving skilled nursing care. Severity: 2 Scope: 3		back from hospital and where required by the physician will obtain and where necessary facility will submit to the division a written request for permission to admit or retain any residence who are prohibited from being admitted or retained as a resident or a residential facility for group. Submitting skilled nursing waiver applications by end of business day	
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of	0878	0878 POC:	02/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	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. Inspector Comments: Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident received medication as prescribed for 1 of 10 sampled residents (Resident #3) and an over the counter medication contained the physician name on the bottle for 1 of 10 sampled residents (Resident #2). Findings		The Wellness Director fixed and addressed items regarding Res #3 Tussin DM having incorrect strength, and Res #2 docusate having no doctor name on bottle. On 02/08/23 Wellness Director performed audit on all meds to all meds are in compliance, and on 02/13/23 provided refresher training to staff. Wellness Coordinator will perform daily audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	include: Resident #3 Resident #3 was admitted to the facility on 07/29/21, with diagnoses including chronic obstructive pulmonary disease, hypothyroidism, weakness/debility, cognitive decline and chronic heart failure. On 02/08/23 at 12:30 PM, Resident #3's medications included a container of Tussin DM liquid 20-400 milligrams (mg), take 10 milliliters (ml) by mouth every eight hours as needed for cough or congestion. Resident #3's January 2023 Medication Administration Record (MAR) and a physician order dated 01/10/23, documented dextromethorphan-guaiFENesin (Tussin DM) 10-100 mg/ml, take 10 ml by mouth every eight hours as needed for cough or congestion. On 02/08/23 at 12:43 PM, the Medication Technician confirmed Resident#3's Tussin DM medication strength did not match the physician order and Resident #3's MAR and verbalized the resident should be receiving the medication as ordered. Resident #2 Resident #2 was admitted to the facility on 10/12/22, with diagnoses including dementia and chronic kidney disease. On 02/08/23 at 1:17 PM, Resident #2's medications included a bottle of docusate sodium 10 mg tablet. Give one tablet by mouth as needed for constipation. The medication bottle lacked the name of the physician. Resident #2's physician order dated 11/07/22, documented docusate sodium 10 mg tablet. Give one tablet by mouth as needed for constipation. Resident #2's January 2023 MAR and a physician order dated 11/07/22, documented docusate sodium 10 mg tablet. Give one tablet by mouth as needed for constipation. On 02/08/23 at 1:17 PM, the Medication Technician confirmed the medication bottle lacked the name of Resident #2's physician. Severity: 2 Scope: 1			
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	0895	0895 POC: On day of survey the Wellness Director fixed and addressed items regarding Res #9 milk of magnesia incorrectly discontinued, Res#7 trazodone there but not in MAR. On 02/08/23 Wellness Director performed audit on all meds to all meds are	02/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	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 clinical record review, document review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 10 sampled residents (Resident #9 and #7). Findings include: Resident #9 Resident #9 was admitted to the facility on 08/12/19, with diagnoses including stage IV chronic kidney disease, hypothyroidism, type II diabetes mellitus, chronic obstructed pulmonary disease and decline in cognition. Resident #9's medication label documented milk of magnesia suspension, take 30 milliliters (mls) by mouth every 24 hours as needed for constipation. Resident #9's physician order dated 10/02/22, milk of magnesia suspension, take 30 mls by mouth every 24 hours as needed for constipation. Resident #9's February 2023 MAR lacked documented evidence of the milk of magnesia medication on the MAR. On 02/08/23 at 1:014 PM, the Medication Technician confirmed Resident #9's medication was not listed on Resident #9's February 2023 MAR. The Medication Technician verbalized a Caregiver had mistakenly discontinued the medication and the order was still active. Severity: 2 Scope: 1 Resident #7 Resident #7 was admitted to the facility on 12/19/22, with diagnoses including heart failure and altered mental status. Resident #7's medication label documented trazodone 50 milligram (mg) tablet, take one tablet by mouth at bedtime for insomnia. Resident #7's physician order dated 02/03/23, documented trazodone 50 mg tablet, take one tablet by mouth at bedtime for insomnia. Resident #7's February 2023 MAR lacked documented evidence of the trazodone on the MAR. On 02/08/23 at 1:23 PM, the Medication Technician confirmed Resident #7's		in compliance, and on 02/13/23 provided refresher training to staff. Wellness Coordinator will perform daily audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	medication was not listed on Resident #7's February 2023 MAR. The Medication Technician verbalized the trazodone was received by the facility on 02/06/23, however the medication had not been administered to the resident. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on interview, clinical record review, and document review, the facility failed to ensure written instructions indicating the specific symptom (s) for which an as needed (PRN) medication was to be administered to a resident was documented for 1 of 10 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 12/27/22, with diagnoses including chronic cognitive impairment and failure to thrive. Resident #6's February 2023 Medication Administration Record (MAR) documented acetaminophen 325 milligram (mg) tablet. Give two tablets by mouth every four hours as needed. The MAR lacked the symptom for which the medication was ordered to treat. Resident #6's physician order dated 12/21/22, documented acetaminophen 650 mg tablet. Give two tablets by mouth every four hours as needed. The physician order lacked the symptom for which the medication was ordered to treat. On 02/08/23 at 1:12 PM, the Medication Technician verbalized Resident #6's February 2023 MAR and physician order lacked the symptom for which the medication was ordered to treat. Severity: 2 Scope: 1	0905	0905 POC: On day of survey the Wellness Director fixed and addressed items regarding Res #6 having no symptoms in PRN order from doctor for acetaminophen. On 02/08/23 Wellness Director performed audit on all meds to ensure all meds are in compliance, and on 02/13/23 provided refresher training to staff. Wellness Coordinator will perform daily audits	02/08/2023
1540	Cultural Competency Training - R016-20	1540		03/31/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS= F	Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 4 of 6 sampled employees required to obtain cultural competency training (Employees #1, #8, #9, and #11). Findings include: On 02/08/23, the Admissions and Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 02/08/23, the Admissions and Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Executive Director with a start date of 04/25/22. The personnel record for Employee #1 lacked a cultural competency training certificate. Employee #8 Employee #8 was hired by the facility as Caregiver/Medication Technician with a start date of 10/30/22. The personnel record for Employee #8 contained a cultural competency training certificate dated 12/15/22. Employee #9 Employee #9 was hired by the facility as Caregiver/Medication Technician with a start date of 06/21/22. The personnel record for Employee #9 contained a cultural competency training certificate dated 12/15/22. Employee #11 Employee #11 was hired by the facility as Caregiver/Medication Technician with a		POC 1540: Business Office Manager did cultural competency training in-service to ensure staff are aware of new hire, and annual renewal requirements, etc. Emp # 1, and #11, completed cultural training through NVHCA on 3/31/23. Business Office Manager is aware of timing requirements to ensure no late certs in future.	3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	start date of 10/30/17. The personnel record for Employee #11 lacked a cultural competency training certificate. On 02/08/23 at 1:34 PM, the Administrator provided the Attestation of Compliance form, signed and dated 02/08/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			
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 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	1700	1700 POC: Wellness director contacted provider immediately and correction was received and in house before survey was complete. Wellness Director and Executive Director will verify prior to any move in that correct box is checked for our environment or per regulation.	02/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

(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
	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 record review and interview, the facility failed to obtain an accurate Placement Determination for 1 of 10 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 10/12/22, with diagnoses including dementia, hypertension, and chronic kidney disease III. Resident #2's Placement Determination dated 10/10/22, documented the resident was appropriate to be placed in a residential facility that provided care to persons with Alzheimer's disease or related dementia. On 02/08/23 at 10:19 AM, the Wellness Director confirmed the facility did not have an Alzheimer endorsement. The Wellness Director verbalized the Physician marked the incorrect box on Resident #2's Placement Determination form. Severity: 2 Scope: 1			