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 _____	09/04/2024

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

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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 09/04/2024. 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 or disabled persons, and/or persons with mental illness, with assisted living services, Category II residents. The census at the time of the survey was 49. Fifteen resident records and ten employee records 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. 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		
0065 SS= E	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 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,	0065	Employee Files for: Employees # 3, 8 and 9 are current and correct. 1. The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2. The Licensed Administrator is	10/01/2024

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	inclusive, and sections 2 to 16 inclusive of this regulation 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) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on interview, personnel record review, and document review, the facility failed to ensure 2 of 10 sampled employees working at the facility greater than 60 days received the required 4 hours of combined tier 1 and tier 2 training in resident care within 60 days of their hiring (Employee#6 and #8) and 2 of 10 sampled employees working at the facility for over a year completed at least eight hours of annual Caregiver training (Employee #4 and #9). Findings include: Employee #4 Employee #4 was hired by the facility as a Medication Aide with a start date of 02/01/2012. Employee #4's personnel file lacked documented evidence of eight hours of annual caregiver training. On 09/04/2024 at 2:25 PM, the Business Manager verbalized Employee #4's file showed only 4 hours were completed in the past 12 months. Employee #6 Employee #6 was hired by the facility as a Caregiver with a start date of 06/05/2024. Employee #6's personnel file lacked documented evidence of 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility within 60 days of hire. On 09/04/2024 at 2:28 PM, the Business Manager verbalized Employee #6's file showed the Tier 1 training certificate was missing. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 05/15/2024. Employee #8's		ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3. Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4. Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a. Daily Stand- Up Meetings b. Monthly In-Service Meetings with staff c. Daily Huddle Meetings with Wellness Team to discuss compliance	

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	personnel file lacked documented evidence of 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility within 60 days of hire. On 09/04/2024 at 2:32 PM, the Business Manager verbalized Employee #8's file showed the Tier 1 training certificate was missing. Employee #9 Employee #9 was hired by the facility as a Medication Aide with a start date of 09/17/2019. Employee #9's personnel file lacked documented evidence of eight hours of annual caregiver training. On 09/04/2024 at 2:35 PM, the Business Manager verbalized Employee #9's file lacked documentation of annual training completed in the past 12 months. Severity: 2 Scope: 2			

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0174 SS= D	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were free from electrical hazards. Findings include: On 09/04/2024 at 12:04 PM, an open electrical junction box, with wire nut splices, was missing the cover plate. This box was located in the riser cabinet of the Gray Cottage. On 09/04/2024 at 12:04 PM, the Maintenance Director verbalized the sprinkler company had performed the annual inspection in August 2024 and left the junction box open. Severity: 2 Scope: 1	0174	Plan of Correction: Survey Date 9.4.24 ID 0174 Plant Supervisor contacted vendor and electrical cover was replaced same day – 9.4.24 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	09/04/2024
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 9/4/24, the facility failed to ensure the	0255	Plan of Correction: Survey Date 9.4.24 ID 0255 Critical Violations: Resources Utilized- NAC 446 1. Multiple Expired Foods: Expired Foods were discarded on 9/4/24 and Official In-Service was conducted on 10/4/24 to address and retrain Dietary	09/09/2024

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	kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. Multiple expired foods in the walk-in refrigeration unit were observed at the time of inspection. The following expiration, best buy, use by or preparation dates were observed: two containers of buttermilk 8/6/24; milk and cream containers 8/23/24; two containers of silk almond milk 7/12/24; cottage cheese 7/31/24; blue cheese 6/27/24; three containers of ricotta cheese. All expired food observed was discarded by end of the inspection. Interview with kitchen staff did not indicate a monitoring system for identifying expired food. b. The Truckee House reach-in refrigerator was at 58 degrees F. at the time of inspection. Potentially hazardous foods stored in the reach-in refrigerator: dairy, mayo, and opened juices were observed at or above 50 degrees F. and were discarded by facility staff at the time of inspection. Other resident housing reach-in refrigeration units also required a maintenance service to ensure good working order. 2. Major Violations: a. Multiple food items stored in plastic baggies in the kitchen walk-in refrigerator were either not labeled and dated or the labels and dates were not legible. b. The floors and walls throughout the kitchen, walk-in refrigerator, dry storage, cook's line, dishwashing area, and janitor's closet were heavily soiled with food debris. c. Bowls were observed stored with-in a container of pasta salad. In addition, pre-cooked bagged food items in the walk-in refrigerator were seeping onto other stored and covered food items. d. Heavily soiled wood shelves were observed with-in the hot holding thermo boxes. In addition, multiple non-food contact areas of the kitchen were heavily soiled: shelving, container lids, utensil storage drawers, and the interior area of the hot holding thermo boxes. e. The following food contact surfaces were soiled or worn: cutting boards and food product shakers (salt/pepper, powdered products). f. The janitor's closet was unorganized and unmaintained. Wet mops were dripping onto boxes and the floor. Chemicals were not accounted and stored properly. Shelves were scattered with		Staff. 2. Reach-in refrigerator in Truckee House was out of range for safe food storage: Vendor, Cool Breeze Fridge Repair was alerted and Reach-in was recalibrated and has remained in compliance temperature. Daily Temperature Logs are used and attached to refrigerator. Major Violations: Resources Utilized – NAC 446 1. Multiple Food Items stored in Plastic Bags not labeled or not legible a. Corrected and retrained staff on labeling 2. Floors and Walls are throughout Kitchens were heavily soiled with Food Debris a. Corrected, retrained staff and instituted new Cleaning and Inspection Schedule 3. Bowls were observed stored within a container of pasta a. Corrected with appropriate scoop 4. Cooked Bagged Food was observed seeping into other stored and covered food items a. Corrected and staff were retrained b. New Cleaning and Inspections Schedule was introduced 5. Heavily Soiled Wood shelves were observed within the hot holding thermos box along with multiple non-food contact surfaces were heavily soiled a. Corrected and staff were retrained b. New Cleaning and Inspection Schedule was introduced	

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	disposable food containers. The janitor's sink was covered with boxes. Severity: 2 Scope: 3		6. Several Food Contact Surfaces were soiled or worn a. Corrected and staff were retrained b. New Cleaning and Inspection schedule was introduced 7. Janitor’s closet was unorganized and unmaintained a. Corrected and staff retrained b. New Cleaning and inspection Schedule was introduced 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with operations Team to discuss compliance	

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0451 SS= D	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 a first aid kit contain the required supplies. Findings include: On 09/04/2024, during the facility tour, the first aid kit in the Gray Cottage did not contain gauze, germicide, adhesive tape, gloves, or a CPR mask. The first aid kit was located on a top shelf cabinet in the medication room, difficult to access by the medication aide (Employee #12). On 09/04/2024, the Medication Aide verbalized the first aid kit did not contain all of the required supplies. Severity: 2 Scope: 1	0451	The First Aid kit at the Gray House was inventoried and the following missing items were replaced: Gauze, germicide, adhesive tape, gloves, CPR mask. The First Aid kit was relocated to more easily accessible location 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	09/05/2024

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0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to develop a person-centered service plan for 2 of 15 sampled residents (Resident #12 and #15). Findings include: Resident #12 Resident #12 was admitted to the facility on 08/14/2023, with diagnoses including knee pain, right hip pain, and mild cognitive impairment. Resident #12's record lacked documented evidence a person-centered service plan had been developed. Resident #15 Resident #15 was admitted to the facility on 08/15/2024, with an unknown diagnosis. Resident #15's record lacked documented evidence a person-centered service plan had been developed. On 09/04/2024 at 9:56 AM, the Executive Director confirmed person-centered service plans had not been developed or reviewed for Resident #12 and #15. Severity: 2 Scope: 1	0515	Person-Centered Service Plan: Park Place Residents #12 and 15 were operating under an Independent Living Agreement. During the 9.4.24 Survey, it was determined Park Place would no longer provide Independent Living Services. A letter was drafted and presented to each resident #12 and 15 to decide whether to continue with Park Place as an Assisted Living Resident or continue in their Independent Living status, but agreeing to relocate to another setting within 30 days. Resident #12 has chosen to remain and her service plan was completed. Resident #15 elected to relocate and would not agree to a service plan. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	10/08/2024
0773 SS= D	Diabetes - NAC 449.2726 Residents having diabetes. (NRS 449.0302) 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident's glucose testing is performed by: (1) The resident himself or herself without assistance; or (2) With the consent of the resident, a caregiver who meets the requirements of NAC 449.196;	0773	Statements were added to the Ultimate User Agreement form, allowing Residents to give permission for Glucose Monitoring and Weights and Measures. Both Residents #1 and #3 were presented with the option to consent or not regarding ongoing Glucose Monitoring and Weights and Measures. Both agreed and signed the addendum to the existing form. A document was included showing proof of the report of Resident #9's	10/07/2024

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	Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure residents gave consent for facility caregivers to perform finger stick blood glucose testing (blood sugar checks) and inject insulin medication prior to the facility caregivers performing the testing and/or injecting insulin medication for 3 of 15 sampled residents (Residents #1, #9, and #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 05/13/2024, with diagnoses including diabetes insipidus, depression, and vascular dementia. An order dated 05/15/2024, and the August and September 2024 Medication Administration Records (MAR) for Resident #1 documented the resident was to receive blood sugar checks four times a day before meals and at bedtime. The MAR had blood glucose levels documented four times daily by the facility staff. On 09/05/2024 at 2:00 PM, a Medication Aide (Med Aide) verbalized the Med Aides performed the blood glucose testing. The Med Aide explained the Med Aide would poke the resident's finger with a lancet to obtain the blood needed for the blood glucose test strip. On 09/05/2024 at 2:10 PM, Resident #1 verbalized the staff performed the blood glucose testing four times a day. The record for Resident #1 lacked a consent for staff to perform the blood glucose testing. Resident #9 Resident #9 was admitted to the facility on 05/04/2023, with diagnoses including type II diabetes mellitus without complications and colostomy status. An order dated 08/04/2023 and the August and September 2024 MARs for Resident #9 documented staff were to check the resident's blood sugar daily before breakfast. The MAR had blood glucose levels documented daily by the facility staff. On 09/05/2024 at 2:05 PM, a Med Aide verbalized the Med Aides performed the blood glucose testing and recorded the result on the MAR for Resident #9. On 09/05/2024 at 2:15 PM, Resident #9 verbalized the staff checked the resident's blood glucose levels. The record for Resident #9 lacked a consent for staff to perform the blood glucose testing. Resident #3 Resident #3 was admitted to		death. Park Place Residents and future Residents will have the choice to consent or not to Glucose Monitoring and Weights and Measures. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	

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	the facility on 06/17/2024, with diagnoses including type II diabetes mellitus without complications and depression, unspecified. An order dated 06/11/2024 and the August 2024 MAR for Resident #3 documented staff were to check the resident's blood sugar daily before meals and administer insulin. The MAR had blood glucose levels documented three times daily by the facility staff and documented two types of insulin injected into the resident up to three times daily throughout the month of August 2024 by facility staff. On 09/05/2024 at 2:08 PM, a Med Aide verbalized the Med Aides performed the blood glucose testing and recorded the results three times daily for Resident #3. The resident was on two types of injectable insulin and the Med Aides injected the insulin for Resident #3 because the resident was not able to independently inject the medications. On 09/05/2024 at 2:21 PM, Resident #3 verbalized the staff checked the resident's blood glucose levels and injected the insulin medications for the resident every day. The record for Resident #3 lacked a consent for staff to perform the blood glucose testing or to inject medications. On 09/05/2024 at 3:29 PM, the Wellness Director confirmed the resident's files lacked consents for blood glucose testing and the facility had not obtained consents from the residents or representatives to have staff perform the blood glucose testing. The Wellness Director confirmed the facility did not obtain resident consents for injectable medications provided to the residents. The facility policy titled "Medication Policy," undated, documented injected vitamin medicines that could not be self-administered by the resident would be provided by Home Health or the provider. Severity: 2 Scope: 1			
0800 SS= D	Residents Requiring Injections-Administration - NAC 449.2728- Residents requiring regular intramuscular, subcutaneous or intradermal injections. 1. Except as otherwise provided by NAC 449.2726, a person who requires regular intramuscular, subcutaneous or intradermal injections must not be admitted to a residential facility or be permitted to remain as a resident of the facility unless the	0800	There were two separate copies of orders for Resident #3's for Lantus and Novolog. Neither were signed by a physician during administration of meds as noted in SOD 0800. The Physician was notified and the orders were signed correctly. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed	10/07/2024

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	injections are administered by: (a) The resident; or (b) A medical professional, or licensed practical nurse, acting within his authorized scope of practice and in accordance with all applicable statutes and regulations, who has been trained to administer those injections. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure the facility could provide the prescribed care for a resident for 1 of 15 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 06/17/2024, with diagnoses including type II diabetes mellitus without complications and depression, unspecified. Resident #3's Medication Verification Form dated 06/11/2024, and unsigned by the provider, documented the resident was on the following medications: -Lantus 10 units at bedtime, subcutaneously, 9 milliliters (ml) pen. -Novolog 5 units before meals, subcutaneously, 9 ml pen. A facility document dated 06/12/2024, listed medical conditions of Resident #3 as diabetes, administration of injections-insulin, and administration of medication on a routine and/or as needed basis and was signed by a physician. Resident #3's Medication Administration Record (MAR) dated August 2024, documented staff were to administer the resident's insulin. The MAR documented daily administration of the following: -Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/milliliter (ml) (Insulin Glargine), inject 10 units subcutaneously at bedtime. -Novolog Injection Solution 100 unit/ml (Insulin Aspart), inject 5 units subcutaneously before meals. On 09/05/2024 at 2:08 PM, a Medication Aide verbalized the Medication Aides injected the insulin for Resident #3 because the resident was not able to independently inject the medications themselves. The Medication Aide confirmed Resident #3 received injected Lantus and Novolog daily from the Medication Aides and thought it was allowed because of the Medication Management class each Medication Aide had taken. On 09/05/2024 at 3:17 PM, the Wellness Director explained		regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	

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	the facility did not have physician orders for Resident #3 to take Lantus or Novolog and had used the unsigned Medication Verification Form as a physician order. The Wellness Director confirmed facility staff had been administering Resident #3's insulin medications subcutaneously. The facility policy titled "Medication Policy," undated, documented injected vitamin medicines that could not be self-administered by the resident would be provided by Home Health or the provider. Severity: 2 Scope: 1			
0859 SS= D	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 record review and interview, the facility failed to ensure physical examination were completed prior to admission and annually for 2 of 15 sampled residents (Resident #12 and #15). Findings include: Resident #12 Resident #12 was admitted to the facility on 08/14/2023, with diagnoses including knee pain, right hip pain, and mild cognitive impairment. Resident #12's record lacked documented evidence an initial or annual physical examination had been completed. Resident #15 Resident #15 was admitted to the facility on 08/15/2024, with an unknown diagnosis. Resident #15's record lacked documented evidence an initial physical examination had been completed. On 09/04/2024 at 9:56 AM, the Executive Director confirmed physical examinations had not been completed for Resident #12 and #15. Severity: 2 Scope: 1	0859	Residents #12 and #15 were living in an Independent Status. Both were given an opportunity to either choose to become an assisted living Resident or choose the 30 Day Move-Out Option. Resident #12 chose to become an assisted living resident and a physical was completed. Resident #15 chose to relocate and will be out within 30 days. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	10/08/2024
0878	Medication/OTCS, Supplements, Change	0878	Resident #11 - A change of direction sticker	10/07/202

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SS= E	Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered,		was affixed to the medication and the administration of the medication was compliant going forward. A training was conducted on 9.26.24. Resident #3 - The order was signed by the physician for the Novalog and Lantus. A Training was conducted on 9.26.24 Resident #14 - TRaining was conducted on 9.26.24 for Medication reordering and clarification of medication orders. The order for Briviact was obtained and the Dantrolene order was corrected by the medication technicians. Resident #7 - The ointment order was clarified and the medication was administered correctly. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	4

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	the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure 1) a medication was given according to the physician order for 1 of 15 sampled residents (Resident #11), 2) a medication change label was affixed to a resident's medication for 2 of 15 sampled residents (Resident #11 and #3), 3) medications were not administered without a signed physician order for 2 of 15 sampled residents (Resident #3 and #14), 4) a prescribed medication was on site and available to administer to a resident for 1 of 15 sampled residents (Resident #14), and 5) a Medication Administration Record (MAR) was accurate for 1 of 15 sampled residents (Resident #7). Findings include: Resident #11 Resident #11 was admitted to the facility on 11/08/2021, with diagnoses including diastolic congestive heart failure and atrial fibrillation. During a medication review on 09/04/2024, Resident #11 had the following documented on the medication container label: -Losartan Potassium oral tablet 25 milligrams (mg), give one tablet by mouth one time a day for congestive heart failure. Resident #11's MAR and the physician order dated 06/24/2024, documented Losartan Potassium 25 mg tablet, give 0.5 (1/2) orally once a day for 90 days. On 09/04/2024 at 2:09 PM, the Medication Aide explained the medication should have had an order change sticker affixed to the medication label and the label did not have a change sticker to reflect the new medication order. The Medication Aide confirmed Resident #11 had received one whole tablet of Losartan Potassium 25 mg from 08/01/2024 through 09/04/2024 and should have received the ordered ½ tablet per the physician's order. Resident #3 Resident #3 was admitted to the facility on 06/17/2024, with diagnoses including type II diabetes mellitus without complications and depression, unspecified. Resident #3's Medication Verification Form dated 06/11/2024, and unsigned by the provider, documented the resident was on the			

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	following medications: -Novolog 5 units before meals, subcutaneously, 9 milliliters (ml) pen. -Lantus 10 units at bedtime, subcutaneously, 9 ml pen. On 09/05/2024 at 2:08 PM, a Medication Aide verbalized the Medication Aides injected the insulin for Resident #3 because the resident was not able to independently inject the medications themselves and confirmed Resident #3 received injected Lantus and Novolog daily from the Medication Aides. The Medication Aide could not produce a physician order for Lantus or Novolog. On 09/05/2024 at 3:17 PM, the Wellness Director explained the facility did not have physician orders for Resident #3 to take Lantus or Novolog and had used the unsigned Medication Verification Form as a physician order. The Wellness Director confirmed facility staff had been administering Resident #3's insulin medications subcutaneously without a physician order. Resident #14 Resident #14 was admitted to the facility on 08/30/2024, with diagnoses including hemiplegia unspecified affecting left nondominant side, cerebrovascular disease, and hyperlipidemia. Resident #14's Medication Verification Form dated 08/15/2024, documented the resident was on the following medications: -Briviact 100 mg one tablet by mouth twice a day. -Dantrolene 25 mg one capsule by mouth twice a day. Resident #14's September MAR documented the following: -Briviact oral tablet 100 mg. Give one tablet by mouth two times a day. The key on the MAR documented a 7 indicated other/see nurse notes. There were 7's on the MAR on 09/02/2024 at 4:00 PM, 09/03/2024 at 7:00 AM, 09/03/2024 at 4:00 PM, and 09/04/2024 at 7:00 AM -Dantrolene Sodium oral capsule 25 mg. Give one tablet by mouth two times a day. On 09/04/2024 at 2:03 PM, during the medication review, Resident #14's medications lacked Briviact and a bottle of Dantrolene Sodium 100 mg documented take one capsule by mouth twice a day. The Medication Aide thought the facility ran out of Resident #14's Briviact on 09/03/2024 and reach out to the pharmacy for a delivery on the dame day. The pharmacy told the Medication Aide the family would bring the medication and the			

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	family verbalized having no refills, so the facility needed to contact the resident's neurologist. The Medication Aide explained the resident missed at least one dose. The Medication Aide verbalized the pharmacy was on a seven-day refill cycle and Resident #14's Briviact was missed because the resident admitted to the facility after the last delivery and before the next delivery. The Medication Aide confirmed the label on the Dantrolene Sodium did not match the MAR or physician order. The Medication Aide explained Resident #14's order for Dantrolene Sodium changed from 25 mg to 100 mg. The Medication Aide explained the facility only had the physician's order for Dantrolene Sodium 25 mg. On 09/04/2024 at 3:43 PM, the Wellness Director verbalized Medical Aides should be checking every day to ensure medications were on site and available. If not, the Medical Aide should contact the physician. The Wellness Director explained the physician was contacted regarding Resident #14's Briviact, but the facility was told to contact the neurologist, so the facility did not have the Briviact to administer. Resident #7 Resident #7 was admitted to the facility on 10/04/2022, with diagnoses including vascular dementia unspecified severity and personal history of transient ischemic attack and cerebral infarction without residual deficits. A physician order dated 07/24/2024, documented Maxitrol 3.5 mg/g -10,000unit/ g-0.1 % eye ointment. Apply one quarter inch every evening. Resident #7's September MAR documented Maxitrol Ophthalmic Ointment 3.5-10,000-0.1 (Neomycin-Polymyxin-Dexamethasone). Instill 0.5 inch in right eye in the evening. Apply one half inch along lower right eye. On 09/04/2024 at 2:33 PM, during the medication review, a medication container documented Neo-Poly-Dex (Neomycin-Polymyxin-Dexamethasone) 0.1%. Place one quarter inch strip to right eye every evening. A Medication Aide confirmed the label on Resident #7's medication container did not match Resident #7's September MAR but should have. On 09/04/2024 at 3:43 PM, the Wellness Director explained a resident's physician order, the label on the medication container, and the MAR should			

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	match. Medication Aides were expected to review medications daily during medication pass. Severity: 2 Scope: 2			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 2 of 11 resident rooms with a resident self-administering medications (Rooms #2 and #6), and for for 1 of 15 sampled residents (Resident #2). Findings include: On 09/04/2024, the following resident rooms contained unsecured medications: 1) Blue Cottage Room #6 -The self-administered medications were stored in an open basket at bedside. At 1:25 PM, the resident verbalized the door was not always locked when out of the room. 2) Blue Cottage Room #2 - The self-administered medications were stored in pill organizers on tables in the bedroom. At 1:30 PM, the resident of Room #2 verbalized not always locking the door when out of the room. On 09/04/2024 at 9:56 AM, the Executive Director verbalized the residents in the Blue Cottage were not admitted as assisted living	0920	Blue house resident #6 Gave a 30 day notice to Move-out. Blue House Resident #2 Moved out of Park place. Resident #2 - The powder and cream were locked and away from the resident. Training was conducted on 9.26.24 for staff regarding medication storage 1. The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2. The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3. Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4. Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a. Daily Stand- Up Meetings b. Monthly In-Service Meetings with staff c. Daily Huddle Meetings with Wellness Team to discuss compliance	10/07/2024

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	residents, but as independent living residents so self-administered medications were not monitored by staff, however, the beds in the Blue Cottage were licensed as Assisted Living beds. The Maintenance Director was present at each discovery. Resident #2 Resident #2 was admitted to the facility on 09/06/2022, with diagnoses including urinary tract infection and encephalopathy. On 09/05/2024 at 2:27 PM, the following were found on the bedside table in Resident #2's room: -Miconazole Nitrate Powder 2 per cent (%) topical powder. -Hydrocortisone External Cream 1% topical cream. On 09/05/2024 at 2:31 PM, the Medication Aide verbalized the hospice staff had left the Miconazole powder and Hydrocortisone cream at Resident #2's bedside but had never received an order from hospice to do so. The Medication Aide explained Resident #2 could not reach the medications on the bedside table, however other residents could reach the medications. The Medication Aide confirmed the medications should have been secured and not left in a resident's room and within reach of other residents. The facility policy titled "Medication Policy," undated, documented medication was not left at the resident's bedside or in cups unattended. Each medication would be given directly to the resident from the original container and would be taken at the time to assure the correct documentation of medication taken. Severity: 2 Scope: 3			

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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 an over-the-counter medication was labeled for 1 of 15 sampled residents (Resident #14). Findings include: Resident #14 Resident #14 was admitted to the facility on 08/30/2024, with diagnoses including hemiplegia unspecified affecting left nondominant side, cerebrovascular disease, and hyperlipidemia. Resident #14's Medication Verification Form dated 08/15/2024, documented the resident was on ASA (Aspirin) 81 milligrams (mg) one tablet by mouth once a day. Resident #14's September Medication Administration Record (MAR) documented Aspirin oral capsule 81 mg. Give one capsule by mouth one time a day. On 09/04/2024 at 2:08 PM, during the medication review, an over-the-counter medication bottle of Aspirin 400 enteric coated tablets 81 mg, lacked a medication label with the contents, name of the resident and the name of the prescribing physician. A Medication Aide confirmed there was no label sticker on the bottle of Aspirin and verbalized the Medication Aide would usually put a sticker on the bottle with the resident's name, the order, and the physician's name. The Medication Aide verbalized there should be a sticker on Resident #14's bottle of Aspirin. Severity: 2 Scope: 1	0923	The bottle of Aspirin was inspected and the label was properly placed on the bottle with the correct labeling items: name of resident, Prescribing physician, name of medication. Training was conducted on proper labeling of OTC medications. 1. The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2. The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3. Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4. Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a. Daily Stand- Up Meetings b. Monthly In-Service Meetings with staff c. Daily Huddle Meetings with Wellness Team to discuss compliance	10/07/2024

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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 record review and interview, the facility failed to ensure 2 of 15 sampled residents met the requirements concerning tuberculosis (TB) screening in accordance with Nevada Administrative Code (NAC) 441A (Resident #12 and #15). Findings include: Resident #12 Resident #12 was admitted to the facility on 08/14/2023, with diagnoses including knee pain, right hip pain, and mild cognitive impairment. Resident #12's record lacked documented evidence an initial or annual TB screening had been completed. Resident #15 Resident #15 was admitted to the facility on 08/15/2024, with an unknown diagnosis. Resident #15's record lacked documented evidence an initial TB screening had been completed. On 09/04/2024 at 9:56 AM, the Executive Director confirmed TB screenings had not been completed for Resident #12 and #15. Severity: 2 Scope: 1	0936	Park Place Residents #12 and #15 were both living in an Independent Living status and asked to either become an assisted Living resident or relocate to continue living in an independent environment. Resident #12 chose to remain at Park Place and was presented with a Physicians Packet and TB documents. Resident #12 completed her TB Documents and is compliant for Park Place Assisted Living. Resident #15 chose to relocate to another Independent setting. The Resident Move In Check list is attached in Documents. A copy of the updated Physicians Packet is attached in documents. page 6 has the new version of the TB document available for compliance completion. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	10/10/2024

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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
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 he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure initial and annual Activities of Daily Living (ADL) assessments were completed for 2 of 15 sampled residents (Resident #12 and #15). Findings include: Resident #12 Resident #12 was admitted to the facility on 08/14/2023, with diagnoses including knee pain, right hip pain, and mild cognitive impairment. Resident #12's record lacked documented evidence an initial or annual ADL assessment had been completed. Resident #15 Resident #15 was admitted to the facility on 08/15/2024, with an unknown diagnosis. Resident #15's record lacked documented evidence an initial ADL assessment had been completed. On 09/04/2024 at 9:56 AM, the Executive Director confirmed ADL assessments had not been completed for Resident #12 and #15. Severity: 2 Scope: 1	0938	All residents are required to have an assessment of ADLs upon Move- In to Park Place Assisted Living. Resident #12 was in an independent living status at Park Place Assisted Living and after receiving a notice from Park Place informing her of Park Place only having Assisted Living units, resident #12 decided to become an assisted living resident and her Assessment for ADLs was completed for Move-in compliance. Resident #15 chose to Move Out of Park Place and his Move out notice was included in the documents. The Move-In Check list was provided as well as a copy of the Physicians Packet for initial Move in assessment of ADLs. The Updated Physicians Packet is also uploaded into Documents with the ADL Assessment being on page 4. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	10/08/2024
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain	1300	Plan of Correction: Survey Date 9.4.24 ID 1300 The Non-Discrimination Notice, displayed in each community has been updated and is	10/01/2024

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	other information; construction of section. [Effective January 1, 2020.] 1. 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 and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. 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 shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 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)		compliant with the Bureau of Health Care Quality and Compliance with the State of Nevada. -The Non-Discrimination Notice is on Page 4 of the Resident Agreement for current and future Park Place Residents -The Non-Discrimination Notice is updated as a stand-alone notice in the Resident Agreement -The updated Non-Discrimination Notice is posted in all 5 Cottages at Park Place and in the Main Office. -The Website for Park Place has been updated to reflect the NRS 449.101 -A Discrimination Binder has been assembled. In it is the Policy stating our position on Non-Discrimination and the steps are listed along with resources to correctly guide anyone in the area of discrimination regarding Park Place 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	

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	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. Inspector Comments: Based on observation, document review, and interview, the facility failed to: (1) ensure there were policies developed to document, investigate, and resolve complaints of discrimination; and (2) ensure a non-discrimination statement with contact information for filing a complaint was posted or included in marketing materials, including the Internet website. Findings include: On 09/04/2024, at 12:51 PM, the Executive Director verbalized the facility's non-discrimination statement did not have the required language, and the facility lacked a written policy for how a non-discrimination complaint would be documented, investigated, and resolved. The Executive Director also verbalized the website's information non-discrimination statement was not in compliance, and did not include contact information for filing a complaint with either the facility or with the Bureau of Health Care Quality and Compliance. The Executive Director confirmed the facility had not established policies regarding non-discrimination complaints, investigations, and resolutions. On 09/04/2024 during the environmental tour of the facility, no public posting of the non-discrimination statement was observed in any of the five resident occupied cottages. Severity: 1 Scope: 3			
1540 SS= E	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 1.	1540	Park Place Assisted Living has very clear Regulations in NRS 449.103 giving clear	10/08/2024

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	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. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the Department or his or her designee pursuant to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 15 3. When a facility submits a course		instructions regarding the Cultural Competency Training for employees. Park Place did not ensure these 4 employees met the regulation within the 30 day limit upon hire. The employees have completed the course and are now in compliance. Employee #6 was terminated and the proof is reflected in the attached document. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	

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	or program pursuant to subsection 1, the facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of the course or program to print and sign his or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of			

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	the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec. 15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource			

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	Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4 of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by federal, state or local government agencies; or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not received or fails to include all of the information that the Director or his or her			

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	designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 4 of 10 sampled employees required to obtain cultural competency training (Employee #3, #6, #8, and #9). Findings include: On 09/04/2024 at 12:45 PM, the Business Office Manager was provided with the Personnel Check List to complete for 10 sampled employees. On 09/04/2024 at 2:15 PM, the Business Office Manager provided the completed form with the following information: Employee #3 Employee #3 was hired by the facility as a Medication Aide with a hire date of 07/31/2024. Employee #3's personnel file lacked a cultural competency training certificate. Employee #6 Employee #6 was hired by the facility as a Caregiver with a start date of 06/04/2024. Employee #6's personnel file contained documented evidence of Cultural Competency training completed 08/21/2024, greater than the required 30 business days. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 05/15/2024. Employee #8's personnel file contained documented evidence of Cultural Competency training completed 08/21/2024, greater than the required 30 business days. Employee #9 Employee #9 was hired by the facility as a Medication Aide with a start date of 09/17/2019. Employee #9's personnel file lacked a cultural competency training certificate. On 09/04/2024 at 2:28 PM, the Business Office Manager verbalized Employees #6 and #8 had completed cultural competency training later than 30 days after hire, Employee #3 had yet to complete training, and Employee #9's certificate was unable to be located. 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	1700	All residents are required to have an assessment upon Move- In to Park Place Assisted Living. Resident #12 was in an independent living status at Park Place Assisted Living and after receiving a notice	10/08/2024

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	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 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		from Park Place informing her of Park Place only having Assisted Living units, resident #12 decided to become an assisted living resident and her Assessment was completed for Move-in compliance. Resident #15 chose to Move Out of Park Place and his Move out notice was included in the documents. The Move-In Check list was provided as well as a copy of the Physicians Packet for initial Move in assessment. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	

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	obtain initial and annual Standard Physician Assessment and Placement Determination's for 3 of 15 sampled residents (Resident #12, #15 and #8). Findings include: Resident #12 Resident #12 was admitted to the facility on 08/14/2023, with diagnoses including knee pain, right hip pain, and mild cognitive impairment. Resident #12's record lacked documented evidence an initial or annual Physician Assessment and Placement Determination had been completed. Resident #15 Resident #15 was admitted to the facility on 08/15/2024, with an unknown diagnosis. Resident #15's record lacked documented evidence an initial Physician Assessment and Placement Determination had been completed. On 09/04/2024 at 9:56 AM, the Executive Director confirmed initial or annual Physician Assessment and Placement Determination's had not been completed for Resident #12 and #15. Resident #8 Resident #8 was admitted to the facility on 01/27/2023, with a diagnosis of dementia. Resident #8's record lacked documented evidence an initial or annual Physician Assessment and Placement Determination had been completed. On 09/04/2024 at 2:22 AM, the Wellness Director/Family Advisor confirmed an initial or annual Physician Assessment and Placement Determination's had not been completed for Resident #8. Severity: 2 Scope: 1			

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1810 SS= F	Infection Control Program - Infection Control Program LCB File No. R048-22 Sec. 5 1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; Inspector Comments: Based on document review and interview, the facility failed to develop an infection control program and corresponding policies to prevent and control infections within the facility. Findings include: On 09/04/2024, at 12:46 PM, the facility lacked a complete infection control program and did not have infection control policies in place to ensure the safety needs of residents, staff, and visitors. The facility's infection control program documented infection control practices including COVID-19 and hand washing but lacked documented evidence of infection control practices and policies for influenza, pneumonia, respiratory syncytial virus (RSV), and other potentially infectious diseases. On 09/04/2024 at 3:40 PM, the Executive Director was not able to produce any documentation of a complete infection control program addressing guidelines for infection control within the facility. Severity: 2 Scope: 3	1810	Infection Control Program is in place - A comprehensive Binder has been created containing General Precautions, Control Plans and Procedures for: Influenza, RSV, Coronavirus, Legionella, Hepatis C, C. Diff, Shingles, Head Lice, Norovirus, Scabies, TB. DPBH Technical Bulletins, Staffing concerns regarding residents, Cleaning and Disinfection, Signage for droplet and airborne. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure. The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	10/21/2024
1840 SS= F	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d)	1840	Park Place Employees #4 and #9 have received the required training to meet the Legislative Counsel Bureau File Number R063-21. The training certificates are attached in Documents. 1.The Policies and Procedures are in place for this Assisted Living Issue – These Policies and Procedures will be followed regarding each appropriate situation. 2.The Licensed Administrator is ultimately responsible for the adherence of and compliance of each policy and procedure.	10/08/2024

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 _____	09/04/2024

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

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	The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 2 of 10 employees obtained the required infection control training required per Legislative Counsel Bureau File Number R063-21, Section 4 (Employees #4 and #9). Findings include: Employee #4 Employee #4 was hired by the facility as a Medication Aide with a start date of 02/02/2012. Employee #4's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. Employee #9 Employee #9 was hired by the facility as a Medication Aide with a start date of 09/17/2019. Employee #9's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. On 09/04/2024 at 2:28 PM, the Business Office Manager acknowledged the lack of documented evidence of required infection control training in the personnel files for Employee #4 and #9. The Business Office Manager verbalized the infection control training had not occurred. Severity: 2 Scope: 3		The Operations Support Team for Park Place Assisted Living is handling daily operations and the daily adherence to the Plan of Correction. 3.Trainings and or recommitment to following the policy and procedures for each situation is our priority. 4.Accountability by the entire Operations Team to the continuance of these commitments will be accomplished through: a.Daily Stand- Up Meetings b.Monthly In-Service Meetings with staff c.Daily Huddle Meetings with Wellness Team to discuss compliance	