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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**12/17/2024**

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 a State Licensure complaint investigation conducted at your facility on 12/17/2024. 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 and provides assisted living services, Category II residents. The census at the time of the survey was 48. Five resident files were reviewed. Two complaints were investigated. Complaint #NV00072800 with the allegation the facility did not provide a resident with a medication for several days resulting in the resident having withdrawal symptoms requiring assessment at an acute care emergency room was substantiated (see tag Y-0871). The following allegations could not be substantiated due to a lack of evidence: Allegation #1 - Medications were not ordered timely, leading to medications not being on site when they needed to be administered. Allegation #2 - A resident had two medications on site and the medications were not on the resident's Medication Administration Record (MAR). Allegation #3 -The facility allowed Tylenol 325 mg tablets to expire prior to requesting new medication. Allegation #4 - Staff attempted to administer medications to resident and the medications did not belong to the resident. Allegation #5 - A resident heard staff members stating a resident's missing medications had been found and the medications had been forgotten and/or left in different places. Allegation #6 - Staff did not pass bedtime medications because a staff member was too tired. Investigation into the allegations included: Observation of resident houses/units, residents in rooms and common areas, resident to resident interactions, staff to resident interactions,	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AMY ROUKIE Title: Executive Director/CIT Date: 03/07/2025

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

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	and call light response times. Interviews were conducted with two residents, two Medication Technicians (MT), the Wellness Coordinator, and the Wellness Director. Clinical record review included face sheets, diagnoses, progress notes, physician orders, Medication Administration Records (MAR), and care plans for five residents including the resident of concern. Document review included the following facility policies: -Abuse and Neglect -Medication Management -Medication Storage -Medication Refills -Expired Medications -Incident reporting -Residence and Care -Resident Rights -Grievance and Complaint Reporting Complaint #NV00072800 with the allegation a resident's shower was not accessible to the resident due to lack of wheelchair access resulting in the resident not being able to utilize the shower was substantiated (see tag Y-0410). The following allegations could not be substantiated due to a lack of evidence: Allegation #1 - A resident did not receive a shower for several days during the month of October and had greasy, unclean hair. Allegation #2- Call lights were not answered for over one hour. Allegation #3- A resident was given a wrong medication. Allegation #4- There was a cat in a resident's unit and the resident was allergic to cats. Allegation #5 -A resident's bathroom did not include grab bars by the toilet resulting in the resident not being able to toilet themselves. Allegation #6: A resident was given another resident's food which included a sandwich cut up into small bites. The investigation into the allegation included: Observation of resident houses/units including resident bathrooms, residents in rooms and common areas, resident to resident interactions, staff to resident interactions, and call light response times. Interviews were conducted with two residents, two Medication Technicians (MT), the Wellness Coordinator, and the Wellness Director. Clinical record review included face sheets, diagnoses, progress notes, physician			

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	orders, Medication Administration Records (MAR), and care plans for five residents including the resident of concern. Document review included the following facility policies: -Abuse and Neglect -Medication Management -Medication Storage - Medication Refills -Expired Medications - Incident reporting -Residence and Care - Resident Rights -Grievance and Complaint Reporting 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:			
0410 SS= D	Accommodations for Residents - NAC 449.227 Accommodations for residents with restricted mobility. (NRS 449.0302) A residential facility with a resident who uses a wheelchair or a walker shall: 1. Have hallways, doorways and exits wide enough to accommodate a wheelchair or walker; 2. Have ramps to accommodate access to areas used by residents; and 3. Provide assistance to such a resident at all steps located inside the facility on the first floor that is entirely above grade Inspector Comments: Based on observation, clinical record review, interview, and document review the facility failed to ensure a resident's shower was wheelchair accessible resulting in the resident not being able to access the shower in the resident's room. Findings include: Resident #1 Resident #1 was admitted to the facility on 08/20/2024, with a diagnosis of chronic obstructive pulmonary disease, unspecified. On 12/17/2024 at 1:13 PM, Resident #1's bathroom shower included a lip approximately 4" in height. The sink was standard height. Resident #1 verbalized the resident would like to be able to access the shower, but explained the lip of the shower was too high, making the	0410	The Community has identified a unit in the community with a roll-in shower to accommodate the needs and desires of resident 1. The room was recently vacated, and the resident was moved into the room with the wheelchair accessible shower. Resident 1 has been satisfied with this room change since that time. No cost was incurred in this move. All future admissions of those using wheelchairs will only be accepted if there is a wheelchair accessible shower room available at the time of move-in. Monitoring of this will continue to include walk-through by the Wellness Director or the Executive Director, to ensure there are no limitations for any of the residents. This was corrected on 12/17/2024. All other residents' rooms and showers have been evaluated to ensure this was not also occurring for our other residents as of 12/17/2024.	01/14/2025

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	shower inaccessible to the resident. The resident voiced feeling frustrated and angry. A State Comprehensive Evaluation form dated 09/26/2024, documented Resident #1 was independent with mobility and could self-propel a wheelchair. Resident #1 did not require assistance to transfer in or out of a bed or chair. Resident #1 required assistance with bathing and was to receive assistance two times per week. On 12/17/2024 at 4:53 PM, the Wellness Director confirmed the shower in Resident #1's bathroom was not wheelchair accessible and confirmed Resident #1 should have been placed in a room with a wheelchair accessible shower. The facility's Resident Handbook, Chapter six, titled "Admission Requirements", undated, documented residents were evaluated prior to admission. The purpose of the evaluation was to ensure residents were placed in the proper environment tailored to the resident's needs. Usually only ambulatory residents were admitted to the facility. However, if an individual was in a wheelchair and could independently transfer from chair to bed and commode, the individual was placed in a specially designed handicapped unit upon the Administrator's approval. The facility policy titled "Resident Bill of Rights," undated, documented the facility provided a safe and comfortable environment and residents were treated with respect and dignity.			
0871 SS= D	Medication Administration - Plan - NAC 449.2742 and R043-22 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which	0871	Multiple trainings were conducted with Medication Technicians to ensure compliance with Medication management. Policies and Procedures were consulted to ensure resources were available to staff at all times. Staff were specifically reminded and retrained to only discontinue a medication if a doctor's order was given. The corrections were completed on 12/17/2024 however all Medication Techs were unable to be trained until 12/18/24. A regular review of all eMARs and an audit is being completed daily to ensure there are no medications discharged erroneously.	01/14/2025

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	ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician, physician assistant or advanced practice registered nurse or other physician, physician assistant or advanced practice registered nurseof the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on observation, clinical record review, interview, and document review the facility		This is completed by the Wellness Coordinator, and/or the Wellness Director in her absence. A thorough review of all eMARs was completed on 12/18/2024 to ensure no additional errors were occurring. Medication orders are also reviewed by the Pharmacy, as required and by the Provider who visits the resident on-site at least monthly. A medication reconciliation is completed at least monthly. Medication cart reviews are completed daily to ensure there are no expired medications on hand and to ensure there are no expired medications given. All medications are ordered with refills to ensure they are received monthly as prescribed and are delivered by the pharmacy. On occasion, medications are not received timely when the family chooses to manage the medication refill process independently by utilizing a different pharmacy. We work diligently with the family to ensure there are no medications that are missed or unavailable due to this process outside of our routine refill process. When there is an issue, we contact both their pharmacy and the family to ensure they both are aware of the pending medication needs. Additionally, if we need a Provider order for the medications to be refilled, that process begins 7 days prior to the end of the current medication supply.	

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	failed to provide a resident with a prescribed medication (duloxetine) for multiple days resulting in the resident having withdrawal symptoms requiring assessment at an acute care emergency room. The failure to ensure duloxetine was not abruptly discontinued for Resident #2 had the potential to lead to adverse outcomes including dizziness, paresthesia, incoordination, and anxiety. Findings include: Resident #2 Resident #2 was admitted to the facility on 08/09/2024, with diagnoses including conversion disorder with seizures or convulsions, and malignant neoplasm of the breast. An Incident Report dated 11/05/2024, documented on 11/05/2024 a caregiver noted Resident #2 was shaking and felt dizzy. The note further documented the resident confirmed feeling shaky and dizzy. The resident was sent to an acute care Emergency Room and did not have any predisposing or physical factors related the resident's shaking and dizziness. A Medication Administration Record (MAR) dated 10/01/2024-10/31/2024, documented Resident #2 was not administered a dose of duloxetine per physician order from 10/23/2024 - 10/31/2024. A MAR dated 11/01/2024 - 11/30/2024, documented Resident #2 was not administered a dose of duloxetine per physician order from 11/01/2024 -11/05/2024. Resident #2 was not administered duloxetine for 15 consecutive days. Resident #2's Comprehensive Care Plan included a care plan titled "Medication and Pharmacy." The care plan documented resident would receive medications as prescribed by the physician. On 12/17/2024 at 4:10 PM, the Wellness Coordinator, explained Resident #2's order for duloxetine was discontinued in error by "someone." The facility was not able to determine who had discontinued the order or why. The Wellness Coordinator confirmed the order was discontinued and should not have been. The Wellness Coordinator confirmed Resident #2 had not received duloxetine			

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	from 10/23/2024 - 11/06/2024 and the medication was stopped abruptly and should not have been. The Manufacturer's guide for duloxetine (Cymbalta), revised on 08/2023 documented patients should be monitored for symptoms when discontinuing treatment with duloxetine. A gradual reduction in the dose rather than abrupt cessation of duloxetine was recommended. The development of potentially life-threatening Serotonin Syndrome had been reported with Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) medications including duloxetine. Serotonin Syndrome symptoms included neuromuscular aberrations, such as incoordination, and mental status changes, such as agitation/anxiety, dizziness, paresthesia (a feeling of pins and needles or electric shocks) and seizures. The facility policy titled "Medications are Permanently Discontinued," undated, documented a designated staff member confirmed physician orders to permanently discontinue the use of a medication and obtained written documentation of the discontinuance from the physician. The facility policy titled " Medication Refusal and/or Missed Doses," undated, documented when medications were missed the prescribing physician was notified immediately.			