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 _____	**04/08/2025**

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 and Facility Reported Incident (FRI) investigation conducted at your facility on 04/08/2025. 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 37. Five resident files and nine employee files were reviewed. The facility received a grade of A. Two complaints and two Facility Reported Incidents (FRI) were investigated. Complaint #NV00073023 was substantiated. The allegation untrained facility staff were providing blood sugar testing and insulin injections was substantiated (see Tag Y1050). Complaint #NV00073896 with the allegation a resident was bedbound without a bedfast waiver and had bed rails up could not be substantiated due to lack of evidence. The investigation into the allegation included: Observations of residents in common areas, residents in resident rooms, and staff and resident interactions. Interviews with three residents, one Medication Technicians, the Wellness Director and the Executive Director. Clinical record review of physician orders, progress notes, person-centered service plans, medication administration records, incident reports. Document review of the facility's April 2025 staffing schedule. FRI #NV11114 was substantiated. The allegation the resident was found unresponsive with a critically low blood sugar and had to be transported to the hospital was substantiated without a deficient practice. FRI #NV10990 with the allegation a resident eloped could not be substantiated due to	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AMY ROUKIE Title: Executive Director/OPS mgr Date: 04/22/2025

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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	lack of evidence. The investigation into the allegation included: Observations of residents in common areas, residents in resident rooms, and staff and resident interactions. Interviews with three residents, the Wellness Director and the Executive Director. Clinical record review of physician orders, progress notes, person-centered service plans, and incident reports. Document review of the facility's Admission Packet and Resident Handbook. 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:			
1050 SS= F	Vital Signs-Glucose - Training/Competency - NAC 449.1985 (1)(a) 1. A caregiver of a residential facility may perform a task described in NRS 449.0304 if the caregiver: (a) Before performing the task, annually thereafter and when any device used for performing the task is changed: (1) Has received training concerning the task that meets the requirements of subsections 5 and 6; and (2) Has demonstrated an understanding of the manner in which the task must be performed; Inspector Comments: Based on personnel file review, document review, and interview, the facility failed to provide training and competency assessment for 6 of 6 employees performing resident blood sugar testing and insulin administration (Employee #4, #5, #6, #7, #8, and #9). Findings include: On 04/08/2025 at 9:00 AM, the Executive Director was provided a selection of Medication Aide personnel for employee training review. On 04/08/2025 at approximately 10:30 AM, the six Medication Aide personnel files were reviewed for blood sugar testing and insulin pen administration training and competency assessment. The facility had been issued a	1050	1. The findings inthis SOD have been corrected as of 4/10/2025. The evidence of this compliancewas sent via email to the surveyor in response to the findings shared duringthe exit conference. We now have a system in place for training all medication techs on the proper use and handling of the diabetic resident. They were trained on thesigns and symptoms of hyper/hypoglycemia. Additionally, they have been trained on the use of the CLIA quality controlprocess for testing diabetic testing supplies to ensure accuracy and to log theresults each time a new canister of test strips are opened. To ensure allpractices related to the diabetic resident are clear, we have outlined them in our training process so we can maintain safety when dealing with the insulin and the testing of blood sugars with this population.	04/10/2025

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	Clinical Laboratory Improvement Amendments (CLIA) Certificate dated 02/20/2024 through 02/19/2026, allowing the facility's staff to use a glucometer to check residents' blood sugars. The following employees performing blood sugar testing and insulin administration, with an insulin pen for insulin dependent diabetic residents in the facility, lacked documented evidence of training by an approved trainer with competency evaluation: - Employee #4 was hired by the facility as a Medication Aide (MA) with a start date of 01/08/2025. - Employee #5 was hired by the facility as an MA with a start date of 01/23/2025. - Employee #6 was hired by the facility as a Wellness Coordinator/MA with a start date of 06/07/2021. - Employee #7 was hired by the facility as an MA with a start date of 12/20/2024. - Employee #8 was hired by the facility as an MA with a start date of 02/01/2012. - Employee #9 was hired by the facility as an MA with a start date of 09/13/2024. On 04/08/2025 at 1:40 PM, the Medication Aide was not able to verbalize how to run controls for the glucometer to ensure the glucometer's accuracy. The MA was not able to verbalize the signs and symptoms to monitor the residents for hypoglycemia or hyperglycemia. On 04/08/2025 at 2:48 PM, the Executive Director (ED) verbalized the facility did not have a policy to address testing resident blood sugars and administering insulin to insulin dependent diabetic residents who could not perform the task themselves. On 04/08/2025 at 2:49 PM, the ED confirmed the Medication Aides' personnel files lacked evidence of a trainer's name and credentials, the curriculum for the blood sugar testing and insulin administration training, evidence of what equipment was used for the training, and competency skills testing for blood sugar testing and insulin administration. Severity: 2 Scope: 3		2. The bestmeasurement of change is to ensure each medication tech is trained PRIOR toworking with diabetic residents. The documentedproof of each training at the beginning of their role as a medication tech, andat least annually thereafter. This documentation will be maintained by theExecutive Director, Wellness Department and Human Resources, in their personnel file. This is a part of their training log that requires all other aspects of their role. 3. Ongoing monitoring ofclinical competencies is required for all medication technicians throughobservation and evaluation by the Wellness Coordinator and/or Wellness Director on a routine basis. The Interim Executive Director will ensure this process is maintained and will also provide monitoring to ensure all diabetic residents are closely monitored for safety. 4. The Interim Executive Director, Wellness Director and Wellness Coordinator are all responsible for ensuring this process is monitored and always practiced. 5. The corrective action was completed on 4/10/2025. 6. See attached documentation which illustrates the training provided.	