STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3659	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KRYSTONS HOME CARE 2	7990 ZINFANDEL DRIVE, RENO, NEVADA ,89506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure Survey conducted at your facility on 07/13/20. 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 is licensed for six Category II Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or intellectual disabilities. The census at the time of the survey was four. Four resident files and six employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		
0072 SS= F	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of	0072	Based on record review and interview, the facility failed to ensure Caregivers who administer medication to residents, employee #2,3,and 4 had completed an annual medication management course taught by an instructor approved by BLCQC , however the instructor of the course was not approved to teach the course at the time. Employee #2,3,and 4 wasn't aware that the instructor who gave the medication management course was not allowed to	08/11/2020

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	NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure Caregivers who administer medications to residents had completed an annual medication management course taught by an instructor approved by the Bureau of Health Care Quality and Compliance (HCQC) for 3 of 4 employees (Employee #2, #3, and #4). Findings include: Employee #2 Employee #2 was hired as the Manager and Caregiver on 12/20/2000. The employee's personnel record documented completion of an annual medication management course on 05/20/20. However, the instructor of the course was not approved to teach the course at the time. Employee #3 Employee #3 was hired as the Assistant Manager and Caregiver on 09/12/02. The employee's personnel record documented completion of an annual medication management course on 05/20/20. However, the instructor of the course was not approved to teach the course at the time. Employee #4 Employee #4 was hired as a Caregiver on 11/07/17. The employee's personnel record documented completion of an annual medication management course on 11/02/19. However, the instructor of the course was not approved to teach the course at the time. 05/24/19: The Instructor's Medication Management Training instructor program expired. 06/07/19: Notice of expired		teach at that time and never informed to either the management. Instructor came to the facility and given medication course training without saying that he wasn't entitled to do so until we were informed by the facility Administrator that the instructor is no longer eligible to teach the training course. Employee #2 #3 immediately made an schedule for the training course to certified medication course trainer and got done recently as certificates attached. Employee #4 made an schedule and will have her course training soon, schedule attached. The facility should check it out first before scheduling any training to any instructor if the trainer for the course is being approved by BLCQC to ensure the deficient practice does not recur. The Administrator is responsible for the plan of correction is implemented and will monitor for compliance. Attachments tag #1,2 and 3.	

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	curriculum/instructors sent to the Instructor. 06/11/19: Instructor was notified by phone the program had expired and the Instructor must submit a new application. 08/15/19: HCQC became aware the Instructor was providing Medication Management Training as an expired instructor. 03/03/20: HCQC became aware the Instructor continued providing Medication Management Training as an expired Instructor. 03/12/20: Notification of expired curriculum/instructor sent to the Instructor via email. 03/13/20: Notification of expired curriculum/instructor sent to the Instructor via certified mail. 04/18/20: The HCQC Medication Management Team received an email from the Instructor requesting to renew the expired Medication Management program. 04/20/20: The HCQC Medication Management Team informed the Instructor to apply as a new provider. New provider applications were sent to the Instructor via email. 04/22/20: The HCQC Medication Management Team received an incomplete application from the Instructor. 04/23/20: The HCQC Medication Management Team notified the Instructor the application was incomplete via email. 04/30/20 and 05/04/20: The HCQC Medication Management Team provided clarification to the Instructor regarding the documents needed to complete the Medication Management application. On 07/13/20 at 1:43 PM, the Assistant Manager verbalized being aware the medication management courses for the three employees would need to be taken again and the facility was in the process of scheduling these courses for the near future. Severity: 2 Scope: 3			
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review and observation, the facility failed to	0088	Based on the document review and observation, the facility failed to prepare a written monthly employee schedule with the number and type of members of the staff assigned for each shift. As it posted on the bulletin board that in the absence of the Administrator there is a Manager or Assistant Manager were in charge of the facility. As far as facility's management concerned, this is just a formality of who's being in charged for everything that concerns the facility on her absence. Manager or Asst Manager doesn't have to	08/11/2020

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	prepare a written monthly employee schedule with the number and type of members of the staff assigned for each shift. Findings include: On 07/13/20 at 8:15 AM, the Manager and the Assistant Manager were not present at the facility at the beginning of the annual State licensure inspection. During a tour of the facility, a document was posted on the bulletin board in the living room indicating in the absence of the Administrator, either the Manager or the Assistant Manager were in charge of the facility. The Assistant Manager arrived at the facility a few minutes later. On 07/13/20 at 12:00 PM, a review of the employee schedule for July 2020 revealed one employee scheduled to be on duty for 07/13/20. This employee was a Caregiver. The Manager's and the Assistant Manager's names were not on the schedule for 07/13/20. A review of the employee work schedules on file revealed neither of these employees were marked on the schedules for 06/14/20 through 07/13/20 as being on duty. On 07/13/20 during a morning medication review, the July 2020 Medication Administration Records (MAR) of the four current residents revealed the Assistant Manager had administered medications to the residents on 07/13/20. A review of the employee work schedule for 07/13/20 did not list the Assistant Manager's name. The review of the July 2020 work schedule revealed employee names filled in for 07/01/20 through 07/14/20 with the remaining dates in July left blank. No times for employees to begin and end their work each day were listed on the schedules for 06/14/20 through 07/13/20. On 07/13/20 at 12:00 PM, the Assistant Manager verbalized the July 2020 employee work schedule was not completed. Severity: 1 Scope: 3		be in the facility each day as long as the caregiver is capable of taking care of the residents that doesn't have a problem going on, any problem arise will inform to the Management to resolve the problem. The posted sign has been there since 2012 with the authorization of the Administrator in her absence was giving the Manager or Asst Manager to be in charge but not to be in the facility at all times since there's a caregiver on duty. Each day the Asst Manager goes to the facility to help out caregiver on duty on daily schedule of work like giving shower to the residents or giving out medication and/ or making breakfast and other stuff without signing in to the staff schedule since he's an assistant manager but eventually you can see his visit to the facility by looking at his initials giving out medications. In every year's survey the facility, surveyors never questioned about why there wasn't any Manager or Asst Manager on duty and only the caregiver who happened to be there at time of survey,with this new regulation, the facility made an employee schedule for a month advance in July for the month of August as attached and employee in charge in behalf of Manager/Asst Manager on duty to be in-charge to ensure the deficient practice does not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance.	

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the Administrator failed to maintain a personnel record with the State Notification of Clearance letter specific to the facility for the criminal background check of 1 of 6 employees (Employee #6). Findings include: Employee #6 Employee #6 was hired on 12/01/18 as a Caregiver. Employee #6's personnel record included a Notification of Clearance letter, dated, 11/30/18. However, the background check clearance letter was not for this facility. The employee's record lacked documented evidence of a State clearance letter for this facility. Nevada's Automated Background Check System (NABS) roster report for the facility, dated 07/10/20, did not include Employee #6's name. On 07/13/20 at 12:10 PM, the Assistant Manager verbalized Employee #6's personnel record did not contain a State Notification of Clearance letter specific to this facility. Severity: 2 Scope: 1	0104	Based on record and interview, the Administrator failed to maintain a personnel record with the State Notification of Clearance letter specific to the facility for the criminal background check. 1 of 5(not 6) employee background check was not for this facility, lacked of documented evidence of the State clearance for the facility but for other facility from (NABS) roster report. Employee #5 used to work at the other facility which is the same company but other facility. She worked there for few months and had taken the (NABS) but there was a time that when you needed a caregiver or help to other facility at the time she was asked to worked there and caregiver for some reason rather work there as per her request but have not taken another fingerprints from (NABS) assuming that she's going back to the other facility where she used to work. Employee #5 at the moment took a medical leave of absence for personal purposes and shall comeback to work if she's able to and will take a state clearance for the facility. Facility should maintain a personnel record with the State Notification of Clearance letter from (NABS) before entering to work in any facility regardless of the same company to ensure the deficient practice does not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance.	08/11/2020

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 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 his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on document review and interview, the facility failed to obtain the results of a general physical examination of a resident by a physician prior to admission for 1 of 4 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral disturbance. The resident was admitted to hospice care on 01/08/20. Resident #1's medical record lacked documented evidence the resident had received a physical examination before moving into the facility. On 07/13/20 at 9:31 AM, the Assistant Manager verbalized an initial physical examination of Resident #1 was not on file. Severity: 2 Scope: 1	0859	Based on the document review and interview, the facility failed to obtain the results of a general physical examination of a resident prior to admission of 1 of 4 residents. Resident #1 was lacked of documented medical record evidence the resident had received a physical examination before moving into the facility. Prior to admission to resident #1, the facility had requested to the sister of resident #1 about all requirements needed on her sister admission, per resident #1 sister everything has been ready in a packet, upon admission, the manager of the facility had checked the needed requirements and the physical examination was missing which means she didn't have a physical examination prior in leaving the facility where the resident #1 came from. Immediately, the manager of the facility called the resident #1 physician and scheduled a visit to give resident #1 physical examination and was given one recently. The facility will make sure that prior to admit a new resident, all requirements should be checked at all times to ensure the deficient practice does not recur. The Administrator is responsible of plan of correction and monitor for compliance. Attachment tag#4	08/11/2020
0872 SS= D	Medication Educ Initial/annual Administrator - NAC 449.2742 -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: (f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training. (g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the	0872	Based on record review and interview, the facility failed to ensure the Administrator had taken the annual medication course taught by an instructor who was approved by BHCQC. The Administrator personnel file documented completion of an annual medication management course on 6/5/20 to an instructor of the course who was not active at that time and the Administrator was not aware at the time prior in taking the course. After finding out that the instructor who had given the course was not active, the Administrator made an schedule to instructor that is approved by BLCQC and had taken the course recently. Prior in taking any course, the facility will make sure that an approved instructor is in active at all times to ensure the deficient practice does not recur. The Administrator is responsible	08/11/2020

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	management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training. (h) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure the Administrator had taken the annual medication management course taught by an instructor who was approved by the Bureau of Health Care Quality and Compliance (HCQC). Findings include: The Administrator was hired on 12/01/12. The Administrator's personnel file documented completion of an annual medication management course on 06/05/20. However, the instructor of this course was not active on the HCQC list of instructors at the time the Administrator took the course. 05/24/19: The Instructor's Medication Management Training instructor program expired. 06/07/19: Notice of expired curriculum/instructors sent to the Instructor. 06/11/19: Instructor was notified by phone the program had expired and the Instructor must submit a new application. 08/15/19: HCQC became aware the Instructor was providing Medication Management Training as an expired instructor. 03/03/20: HCQC became aware the Instructor continued providing Medication Management Training as an expired Instructor. 03/12/20: Notification of expired curriculum/instructor sent to the Instructor via email. 03/13/20: Notification of expired curriculum/instructor sent to the Instructor via certified mail. 04/18/20: The HCQC Medication Management Team received an email from the Instructor requesting to renew the expired Medication Management program. 04/20/20: The HCQC Medication Management Team informed the Instructor to apply as a new provider. New provider applications were sent to the Instructor via email. 04/22/20: The HCQC Medication Management Team received an incomplete application from the Instructor. 04/23/20: The HCQC Medication Management Team notified the Instructor the application was incomplete via email. 04/30/20 and		for ensuring the plan of correction is implemented and monitor for compliance. Attachment tag #5	

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	05/04/20: The HCQC Medication Management Team provided clarification to the Instructor regarding the documents needed to complete the Medication Management application. On 07/13/20 at 1:43 PM, the Assistant Manager verbalized the Administrator was aware of the need to retake the medication management course and was in the process of scheduling it for the near future. Severity: 2 Scope: 1			
0874 SS= D	Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the Administrator failed to ensure a six-month pharmacy review was initialed for 1 of 4 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral disturbance. Resident #1's medical records included two pharmacy reviews, dated 02/20/20 and 04/15/20. Both of these documents lacked the initials of the Administrator. On 07/13/20 at 9:31 AM, the Assistant Manager verbalized the two pharmacy reviews lacked the Administrator's initials. Severity: 2 Scope: 1	0874	Based on the record and interview, the Administrator failed to ensure a six-month pharmacy review was initialed for 1 of 4 residents. Resident #1 pharmacy reviews dated 2/2/20 and 4/15/20 both of these documents lacked the initials of the Administrator. Two medication review were missed Administrator's initials on 2/2/20 and 4/15/20 were verbalized by Asst. Manager. Every pharmacy review should be initialed by an Administrator at all times to ensure the deficient practice does not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance.	08/11/2020
0878 SS= E	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered	0878	Based on the observation,record review and interview, the facility failed to ensure dietary supplements were given to resident #1. Caregiver #1 showed the Inspector a bottle of chocolate nutritional shake and declared giving resident #1 the supplemental shake three times a day to a resident with lacked of documented evidence the resident's physician had ordered chocolate nutritional shakes for the resident as Assistant Manager verbalized the hospice nurse and resident's daughter	08/17/2020

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	in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure 1) dietary supplements were given to residents under physician orders for 1 of 4 residents (Resident #1) and 2) physician orders for medications were on file for medications being administered to 1 of 4 residents (Resident #4). Findings include: On 07/13/20 at 11:15 AM, Caregiver #1 showed the Inspector a bottle of chocolate nutritional shake and declared giving these drinks to the residents every day. Caregiver #1 verbalized giving Resident #1 the supplemental shake three times per day. Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral		recommended giving resident #1 the chocolate nutritional shake. The Assistant Manager verbalized Resident #1 physician had not ordered the nutritional shakes and none of the residents had not ordered the nutritional shakes from her physician. ON 8/17/20 resident #1 physician discontinued nutritional shakes as requested. Prior in giving any dietary supplement or over the counter medication may be given to a resident only if the resident's physician has approved the administration of the medication supplement must be prescribed by a physician to ensure the deficient practice will not occur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance. Attachment tag #6. Resident #4 was admitted to the facility on 7/1/20 contained a list of medication, however, the record lacked physician orders for the medications on the list. Caregivers had administered all the medications that brought to the facility. Prior to admission of resident #4, the facility manager informed all list of requirements upon checking in of resident #4's sister who happened assisting her sister to place in the facility and was informed all the requirements to be brought upon admitting her and this includes the list of physician medication order, a packet of envelope was given to the manager and upon checking, a physician order medication was missing and resident #4 sister was saying that it'll be hard to get back to the facility to get it because of the situation. The facility Manager immediately called a new physician to assist the resident #4 to assist her with her medication list and accepted the resident and scheduled a visit. A new order of physician medication list attached of resident #4 to ensure that deficient practice will not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance. Attachments Tag #7,#8 and #9	

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	disturbance. Resident #1's medical record lacked documented evidence the resident's physician had ordered chocolate nutritional shakes for the resident. On 07/13/20 at 11:24 AM, the Assistant Manager verbalized the hospice nurse and the resident's daughter recommended giving Resident #1 the chocolate nutritional shake. The Assistant Manager expressed buying "lots of nutritional shakes" for the residents because "it is good for them." The Assistant Manager verbalized Resident #1's physician had not ordered the nutritional shake and none of the residents had a physician's order for this supplemental drink. Resident #4 Resident #4 was admitted to the facility on 07/01/20 with diagnoses including acute and chronic respiratory failure, dysphagia, and other recurrent depressive disorders. Resident #4's medical record contained a list of medications, dated February 2020, from the resident's previous place of residence. However, the record lacked physician orders for the medications on the list. On 07/13/20, according to the resident's July 2020 Medication Administration Record (MAR), the Caregivers had administered the following medications to Resident #4 since the beginning of July: - doxepin hydrochloride (HCL) 10 milligram (mg) cap, 1 cap oral at bedtime - Travatan Z 0.004% ophthalmic solution 5 milliliters (ml), instill 1 drop in both eyes once daily at bedtime - dozolamide hydrochloride timolol maleate ophthalmic solution, drop into both eyes twice a day - nystatin (Nystop) 100,000 unit/gram powder mycostatin, apply thin layer topically twice a day - Mega Red 500 mg omega 3 dietary supplement, daily - Oscar calcium+D3 500 mg calcium 200 international units vitamin D3, daily - metoprolol 25 mg tab, take 1/2 tab by mouth twice daily - pantoprazole 40 mg tab, take 1 tab by mouth every day - simvastatin 20 mg tab, take 1 by mouth every day at bedtime - furosemide 40 mg tab, 1 tab oral twice a day - potassium chloride 20 milliequivalent tab, tab oral twice a day - gabapentin 100 mg capsule, oral three times a day - oxybutynin chloride 10 mg tab, 1 tab oral once a day - dicyclomine 10 mg, 1 cap oral once a day - aripiprazole 20 mg, 1 tab oral at bedtime - Xarelto 20 mg tab, 1 tab oral			

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	once at bedtime - atorvastatin 10 mg, 1 tab oral at bedtime for simvastatin 20 mg - mirtazapine f/c 45 mg, 1 tab oral at bedtime, take 1 tab for depression/low appetite On 07/13/20 at 10:30 AM, the Assistant Manager explained Resident #4 did not have an established physician upon admission, the facility did not have documented physician's orders for the medications which arrived with the resident upon admission, and the facility had been administering these medications to the resident since admission. However, the facility was trying to find a new physician for the resident. Severity: 2 Scope: 2			

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0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, document review, and interview, the Administrator failed to ensure the accuracy of transcriptions in its Medication Administration Records (MAR) for 1 of 4 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 03/26/20 with diagnoses including Parkinson's disease, type II diabetes, and lymphoma. Resident #2's July 2020 MAR documented the following: - senna plus 8.6 50 milligram (mg), take 2 tabs by mouth once a day. - Senexon-S 8.5 50 mg, take 2 tab by mouth twice daily, hold for loose stool. The July 2020 MAR documented Caregivers had administered both of these medications to the residents from 07/01/20 to 07/13/20. On 07/13/20 at 10:44 AM, the Assistant Manager verbalized the resident was being given Senexon and not being given Senna Plus, even though the July 2020 MAR listed both medications and documented they both had been administered to the resident in July. Severity: 2 Scope: 1	0895	Based on observation, document review, and interview, the Administrator failed to ensure the accuracy of transcriptions in it's Medication Medication Record (MAR), resident #2 documented two medications administered both to residents and verbalized by Asst Manager that both medications and documented, they both had administered in July that resident #2 was given Senexon and not being given Senna Plus even though the July 2020 MAR listed both medications had been administered to the resident in July. As per an interview of Asst Manager, Senexon and Senna plus were only one medication as prescribed but the caregiver #4 wrote on MAR individually and admitted her mistake. Asst Manager confirmed the changes and corrected. The facility should always ensure the accuracy of transcriptions in it's MAR to ensure the deficient practice does not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance.	08/17/2020
0905 SS= F	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken	0905	Based on observation, record review and interview, the facility failed to ensure a symptom was listed on Medication Administration Record (MAR), for 2 of 4 residents (resident #1 and resident #3 and a PRN medication was not administered if the symptom for which the medication was needed had not been documented for 1 of 4	08/17/2020

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	as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure a symptom was listed on the Medication Administration Record (MAR) for each as need (PRN) medication for 2 of 4 residents (Resident #1 and Resident #3) and a PRN medication was not administered if the symptom for which the medication was needed had not been documented for 1 of 4 residents (Resident #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral disturbance. The resident was admitted to hospice care on 01/08/20. The resident's July 2020 MAR documented banophen 25 milligram (mg) tablet, take 1 tab by moth every 4 hours as needed. The MAR lacked notation of the reason for this medication. On 07/13/20 at 10:54 AM, the Assistant Manager verbalized the lack of symptom listed for Resident #1's banophen prescription. Resident #3 Resident #3 was admitted to the facility on 07/05/20 with diagnoses including amyotrophic lateral sclerosis, suspect liver cancer, and osteoporosis. The resident's July 2020 MAR documented: - hydroxyzine hydrochloride (HCL) 25 mg, take 1 tab my mouth every 8 hours as needed. - docusate 100 mg capsule, take 1 cap by mouth at bedtime as needed. The MAR lacked notation of the reasons for these medications. The resident's medical record contained a physician order for hydroxyzine hydrochloride (HCL) 25 mg, take 1 tab my mouth every 8 hours as needed. The physician order lacked notation of the reason for this medication.		residents. Resident #1 was admitted to the hospice care and MAR documented banophen every 4 hrs as needed. The MAR lacked notation for the reason for this medication. Resident #3 as needed 2 medications hydroxyzine and hydrocloride on medical record lacked of notation as MAR documented an as needed medication and no symptom were listed on the MAR and 2 caregivers were listed had administered to the resident for different dates. The physician medication order were lacked notation of the reason for these medications on MAR. The Asst manager verbalized no symptoms were listed on the MAR for 2 medications and the caregivers had administered these medications to resident #3 without symptom for this medication being documented on the MAR. Caregiver on duty were informed to notate all symptoms when giving as needed medication to ensure the deficient practice does not recur. The Administrator is ensuring the plan of correction is implemented and monitor for compliance.	

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	The resident's July 2020 MAR documented two Caregivers had administered hydroxyzine HCL to the resident on 07/06/20, 07/07/20, 07/08/20, and 07/09/20. On 07/13/20 at 11:00 AM, the Assistant Manager verbalized no symptoms were listed on the MAR for hydroxyzine and docusate and the caregivers had administered hydroxyzine to Resident #3 in July without the symptom for this medication being documented on the MAR. Severity: 2 Scope: 3			

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0920 SS= D	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, record review, and interview, the facility failed to ensure an over-the-counter (OTC) medication was stored in a secure location for 1 of 4 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral disturbance. The resident was admitted to hospice care on 01/08/20. The resident's July 2020 Medication Administration Record (MAR) documented Silvadene 1% cream, apply a small amount topically to wounds three times per day. On 07/13/20 during the morning review of Resident #1's MAR and medications, the Assistant Manager walked to the resident's room and retrieved a jar of Silvadene cream. On 07/13/20 at 10:51 AM, the Assistant Manager verbalized having applied the cream onto the resident's skin earlier in the morning and failing to return the jar to its storage bin. Severity: 2 Scope: 1	0920	Based on the observation and interview, the facility failed to ensure an over-the-counter (OTC) medication was store in a secure location for 1 of 4 residents. Resident #1 was using Silvadene 1% cream on jar applied on her skin but retrieved the jar from resident's room. Based on the interview to the Asst Manager, he verbalized retrieved the jar a little earlier from a secured medicine cabinet storage and was intentionally left the jar on resident's room ready to apply it to resident #1 skin but never leave it to resident's room all day. Any OTC or prescribed medication should be locked in secured box at all times to ensure the deficient practice does not recur. The Administrator is responsible to ensure plan of correction is implemented and monitor for compliance.	08/17/2020

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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, record review, and interview, the facility failed to ensure medication containers were labeled for 1 of 4 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 07/01/20 with diagnoses including acute and chronic respiratory failure, dysphagia, and other recurrent depressive disorders. The resident was under hospice care since 03/31/20. The resident's July 2020 Medication Administration Record (MAR) documented dorzolamide hydrochloride timolol maleate ophthalmic solution, drop into both eyes twice a day. On 07/13/20 during the morning medication review, a container of the resident's eye drops lacked a label with resident's name and the prescribing physician. On 07/13/20 at 10:35 AM, the Assistant Manager verbalized the container of eye drops for Resident #4 needed to be labeled. Severity: 2 Scope: 1	0923	Based on the observation, record review and interview, the facility failed to ensure medication containers were labeled for 1 of 4 residents. Resident #4 was using eye drops in her eyes twice a day but the container of the resident's eye drops lacked of label of residents name and prescribing physician. Per Asst Manager, the sister of resident #4 brought the eye drops bottle to the facility to use for her sister and the Asst Manager asked where the box was of the eye drops bottle where you can read the name of resident and prescribing physician and was informed the sister of resident #4 that it wasn't acceptable. Asst Manager ordered a new eye drops from prescribing physician with complete labeled to ensure the deficient practice does not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance. Attachments tag #12 and #13	08/17/2020

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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 document review and interview, the facility failed to ensure 1 of 4 residents met the requirements concerning tuberculosis (TB) testing (Residents #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral disturbance. The resident was admitted to hospice care on 01/08/20. Resident #1's medical record documented a negative 2-step TB test, with the second step being read on 05/15/19. The medical record lacked evidence Resident #1 had received a TB test in 2020. On 07/13/20 at 9:31 AM, the Assistant Manager verbalized knowing the TB test for Resident #1 was overdue and the facility was in the process of scheduling a 2-step TB test for the resident in the near future. Severity: 2 Scope: 1	0936	Based on document review and interview, the facility failed to ensure 1 of 4 residents met the requirements concerning tuberculosis (TB) testing. Residents #1 medical record documented a negative 2 steps TB on 2019, but lacked of evidence of TB testing on 2020. Resident #1 was scheduled to have a TB testing prior to expire her 2019 previous TB testing, but due to the busiest time of the person who's able to come to give a service to the facility, the schedule was being cancelled due for some reason of the person doing the TB testing since resident #1 can't walk and hard to transport to go somewhere else to have a TB testing because of her health condition, she was being re- scheduled and had TB testing on the past due date and so she was able to do 2 steps on 7/18/20 and 08/01/20. The facility will make sure that prior to a due date of TB testing, should schedule way ahead of time to ensure the deficient practice does not recur. The Administrator is responsible for ensuring plan of correction is implemented and monitor for compliance. Attachment tag #14	08/17/2020

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0960 SS= D	Alzheimer's Care Application for Endorsement - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer ' s disease. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on document review and interview, the facility failed to obtain an endorsement to serve persons with Alzheimer's disease or related dementia for 1 of 4 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/26/19 with diagnoses including senile degeneration of the brain and unspecified dementia with behavioral disturbance. The resident was admitted to hospice care on 01/08/20. The resident's medical record lacked documented evidence of a signed Physician Placement Determination form indicating the facility was an appropriate place for Resident #1 to live. On 07/13/20 at 9:31 AM, the Assistant Manager verbalized no Physician Placement Determination form was on file and the facility was not endorsed to care for persons with Alzheimer's disease or related dementia. Severity: 2 Scope: 1	0960	Based on document review and interview, the facility failed to obtain an endorsement to serve persons with Alzheimer's disease or related dementia for 1 of 4 residents. Resident #1 medical records lacked of evidence of a signed Physician Placement Determination form indicating the facility was appropriate place for Resident #1 to live. Upon admitting the resident #1 on 8/26/19, there was still a bit of communication with the resident #1 and can still understand you are able to talk to her. After few months, the Manager of the facility observed changes of resident #1 starting to have a little dementia unknowingly she will still be an alert like when she was admitted. The facility Manager mentioned the observance to resident #1 physician and needed to obtain a Physician Placement Determination if resident #1 still be able to live in the same facility of having a dementia. On the next visit of resident #1 physician, he was asked to fill out the Physician Placement Determination forms to ensure the deficient practice does not recur. The Administrator is responsible for plan of correction is implemented and monitor for compliance. Attachments Tag #15, 16, 17 and 18	08/17/2020