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 _____	09/16/2021

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 in your facility on 09/16/21. 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 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or intellectual disabilities, Category II residents. The census at the time of the survey was five. Five resident files and five employee files were reviewed. The facility received a grade of A. 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		
0870 SS= F	Medication Administration-Accuracy & Report - 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: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to	0870	Based on 09/16/21 review, record and interview, the facility failed to ensure a medication profile review that resident #1,#2, #3, #4 and #5 medication review was unable to provide by facility that should be reviewed and signed by physician, pharmacist or nurse once every six months, instead a physician's progress note for resident #1,#2, #3, #4 and #5 contained a list of medications but lacked of documented evidence were reviewed and not provided by Assistant Manager. The Assistant Manager was assuming the physician's progress note with medications list attached that they were considered as reviewed since they were written by resident's physicians and were recognized by the sister facility on the same situation on previous survey and not corrected. Per the surveyor to the assistant manager that he'll be asking his supervisor if these are acceptable or they can be reviewed by a physician, nurse or pharmacist as requested. Facility should complete a medication review by their physicians, nurse or pharmacist every six month to ensure the	09/27/2021

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	paragraph (a). Inspector Comments: Based on document review, record review and interview, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 5 of 5 residents residing in the facility for longer than six months (Resident #1, #2, #3, #4, and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/01/20 with diagnoses including hypertension, anxiety, urinary incontinence, gastroesophageal reflux disease and chronic kidney disease. Resident #1's medical record documented a six-month medication profile review, dated 01/12/21. Resident #1's medical record lacked a six-month medication profile review completed by 07/12/21. On 09/16/21 at 10:28 AM, the Assistant Manager was unable to provide documented evidence of the medication review. The Assistant Manager expressed the resident's physician assistant completed the six month medication reviews when the physician's assistant assessed the resident. The Assistant Manager provided the physician's progress note for Resident #1 dated, 03/18/21, however, the progress note contained a list of current medications, but lacked documented evidence the medications were reviewed during the assessment. Resident #2 Resident #2 was admitted to the facility on 10/20/20 with diagnoses including bipolar disorder, depression, hyperlipidemia, schizoaffective disorder and hypertension. Resident #2's medical record lacked documented evidence of a six-month medication profile review completed by 04/20/21. On 09/16/21 at 10:09 AM, the Assistant Manager confirmed the finding and verbalized Resident #2 did not have a six-month medication profile review completed within six months of admission. Resident #3 Resident #3 was admitted to the facility on 09/29/20 with diagnoses including hypothyroidism, anxiety, anemia, essential hypertension and hyperlipidemia. Resident #3's medical record lacked a six-month medication profile review completed by 03/29/21. On 09/16/21 at 10:28 AM, the		deficient practice does not recur and the Administrator is responsible for ensuring the plan of correction is implemented and to monitor for compliance.	

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	Assistant Manager was unable to provide documented evidence of the medication review. The Assistant Manager expressed the resident's physician assistant completed the six month medication reviews when the physician's assistant assessed the resident. The Assistant Manager provided the physician's progress note for Resident #3 dated, 03/18/21, however, the progress note contained a list of current medications, but lacked documented evidence the medications were reviewed during the assessment. Resident #4 Resident #4 was admitted to the facility on 10/12/20 with diagnoses including hyponatremia, alcohol abuse and asthma. Resident #4's medical record lacked documented evidence of a six-month medication profile review by 04/12/21. On 09/16/21 at 10:28 AM, the Assistant Manager was unable to provide documented evidence of the medication review. The Assistant Manager expressed the resident's physician assistant completed the six month medication reviews when the physician's assistant assessed the resident. The Assistant Manager provided the physician's progress note for Resident #4 dated, 03/18/21, however, the progress contained a list of current medications, yet lacked documented evidence the medications were reviewed during the assessment. Resident #5 Resident #5 was admitted to the facility on 10/15/20 with diagnoses including hypertension, urinary incontinence, depression and schizophrenia. Resident #5's medical record lacked documented evidence of a six-month medication profile review by 04/15/21. On 09/16/21 at 10:28 AM, the Assistant Manager was unable to provide documented evidence of the medication review. The Assistant Manager expressed the resident's physician assistant completed the six month medication reviews when the physician's assistant assessed the resident. The Assistant Manager provided the physician's progress note for Resident #5 dated, 03/18/21, however, the progress contained a list of current medications, yet lacked documented evidence the medications were reviewed during the assessment. Severity: 2 Scope: 3			

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure a medication did not require an assessment of the resident's condition prior to administration for 1 of 5 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 09/29/20 with diagnoses including hypothyroidism, anxiety, anemia, essential hypertension and hyperlipidemia. The resident's physician order, dated 08/19/21, documented nortriptyline 10 milligrams (mg), take one to three capsules by mouth at bedtime. Resident #3's September 2021 Medication Administration Record (MAR) documented nortriptyline 10 milligrams (mg), take one to three capsules by mouth at bedtime. The medication basket for Resident #3 contained a bubble pack containing nortriptyline 10 milligrams (mg), take one to three capsules by mouth at bedtime. On 09/16/21 at 10:17 AM, the Assistant Manager confirmed the physician order, the MAR and the medication on-site contained a range and verbalized not knowing a range could not be ordered. Severity: 2 Scope: 1	0876	Based on document review and interview, the facility failed to ensure a medication did require an assessment of the resident's condition prior to administration. Resident #3 physician order of medication dated 08/19/21 documented nortriptyline 10 mg , take 1-3 capsules by mouth at bedtime as copied on MAR by facility as documented by her physician which the facility was not aware of the contained a range could not be ordered. The resident physician is new and just took over from the previous physician awaiting for her to visit the facility to correct the medication order to ensure the deficient practice does not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance.	09/27/2021
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	0936	Based on record , review, document review the facility failed to ensure 2 of 5 residents met the requirements concerning tuberculosis testing. Resident #2 medical record lacked of 2-step or quantiferon upon admission on 10/19/20 but was noted by a consultant progress on her file by the	09/27/2021

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	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, document review and interview, the facility failed to ensure 2 of 5 residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441a (Resident #2 and #5). Findings include: Resident #2 Resident #2 was admitted to the facility on 10/20/20 with diagnoses including bipolar disorder, depression, hyperlipidemia, schizoaffective disorder and hypertension. Resident #2's medical record lacked documented evidence of a 2-step Tuberculin TB test or QuantiFERON laboratory TB test upon admission. On 09/16/21 at 10:09 AM, the Assistant Manager confirmed the finding and verbalized residents are required to meet the TB testing requirements upon admission. Resident #5 Resident #5 was admitted to the facility on 10/15/20 with diagnoses including hypertension, urinary incontinence, depression and schizophrenia. Resident #5's medical record documented a 2-step TB test for admission. The first step was given on 10/03/20 at 4:15 PM and read negative on 10/06/20 at 9:10 AM. The second step was given on 10/13/20 at 5:00 PM and read negative on 10/15/20 at 9:58 AM, not meeting the requirement to be read between 48 and 72 hours after given. On 09/16/21 at 10:26 AM, the Assistant Manager confirmed the finding and verbalized the TB test needed to be read after 48 hours and before 72 hours. Severity: 2 Scope: 1		previous facility that she was given a quantiferon tb test on 10/19/20 but no evidence of lab taken. Attached copy of her new TB test taken on 09/20/21. Facility should ensure before admitting a new resident that their file should be completed to ensure that the deficient practice does not recur and the Administrator is ensuring the plan of correction is implemented and to monitor for compliance. Attachment tag #1 Resident #5 medical record documented a 2-step tuberculin TB upon admission which the first step was given on 10/03/20 at 4:15 pm and read negative on 10/6/20 at 9:10 am but the second step was given on 10/13/20 at 5:00 pm and read negative on 10/15/20 at 9:58 am , not meeting the requirement to be read 48-72 hours after given. The record per her file came from other facility before moving in and brought her files upon admission. The facility should check all files of residents to be completed to ensure the deficient practice does not recur and Administrator is responsible for ensuring the plan of correction is implemented and to monitor for compliance.	

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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 interview, document review and record review, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 5 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/01/20 with diagnoses including hypertension, anxiety, urinary incontinence, gastroesophageal reflux disease and chronic kidney disease. Resident #1's medical record documented an admission ADL assessment was dated 09/01/20. Resident #1's medical record lacked documented evidence of an ADL assessment for 2021. On 09/16/21 at 10:07 AM, the Assistant Manager confirmed an annual ADL Assessment had not been completed for Resident #1 for 2021. Severity: 2 Scope: 1	0938	Based on interview document review and record review, the facility failed to ensure an Activities of Daily Living was completed annually for 1 of 5 residents. Resident #1 had completed 2020 ADL upon admitted on 9/1/20 but unable to assess on 9/1/21 but being assessed on 9/16/21. The facility failed to overlooked resident #1 file annual ADL for 9/1/21 to ensure the deficient practice does not recur and the Administrator is responsible for ensuring the plan of correction is implemented and to monitor for compliance. Attached copy of her new ADL dated 9/16/21. Attachment tag #2	09/27/2021