Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	370	A. BUILDING ____________________ B. WING ______________________	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA PLACE RETIREMENT COMMUNITY	**1111 W COLLEGE PARKWAY, CARSON CITY, NEVADA ,89703**

(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 annual grading survey conducted at your facility on 08/07/2024. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 76 Residential Facility for Group, Category II beds for elderly or disabled persons, with assisted living services. The census at the time of the survey was 62. Fifteen resident files were reviewed, and 12 employee records were reviewed. The facility received a grade of D. Your facility has received a C or D grade for this inspection. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MELISSA QUARANTO Title: Adminstrator Date: 09/30/2024

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0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 8/7/24, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. The walk-in freezer was not holding temperature to ensure food remains frozen at the time of inspection. The temperature of the freezer was observed at 25 degrees F. In addition, the condenser drain lines were frozen over indicating an issue with the system. 2. Major Violations: a. The stove and griddle internal components were heavily soiled with grease and food debris at the time of inspection. b. The trash compactor was seeping liquid waste onto the enclosure concrete pad at the time of inspection. Severity: 2 Scope: 2	0255	n 8/7/2024, Burney's Commercial Service of Nevada Inc. found that the high psi switch was not closing, installed switch. On 8/29/2024, MG Builders LLC welded trash compactor. The Dining Services Director will be responsible for conducting daily inspections of kitchen equipment and cleanliness, as well as monitoring freezer and refrigerator temperatures. Plant Operations Director will conduct weekly audits of kitchen equipment, temperature logs, and the trash compactor area to ensure compliance. We will add kitchen and sanitation compliance to the QA agenda for review during monthly meetings for the next 6 months. Any issues identified will be addressed promptly, and corrective actions will be implemented as needed.	08/29/2024

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0451 SS= C	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure expired medications in first aid kits were destroyed for 3 of 3 first aid kits. Findings include: On 08/07/2024 at 10:45 AM, the unopened first aid kit in the third floor had an expiration date of 03/31/2023. The unopened first aid kit on the second floor had an expiration date of 04/30/2023. The first aid kit on the opened first floor had an expiration date of 04/30/2023. Medications (acetaminophen and decongestant) and germicide within the opened first aid kits were dated as expired on 04/30/2023. On 08/07/2024 at 10:45 AM, the Plant Ops Director Services verbalized the first aid kits were expired and would be replaced. Severity: 1 Scope: 3	0451	On 9/24/2024, all 3 first aid kits have been ordered and will be placed in the backpacks as soon as they arrive on 9/26/2024. We will complete monthly inspections, documentation of inspections, removal and replacement of expired items, and the safe destruction of expired medications. Implement a First Aid Kit Monitoring Protocol to ensure that all kits are inspected monthly. This will include a checklist for each kit to verify that all contents are within their expiration dates. We also be responsible for documenting the removal, replacement, and destruction of expired medications.	09/24/2024

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on clinical record review, document review and interview, the facility failed to ensure an annual general physical examination with a review of systems was completed timely for 2 of 15 sampled residents (Resident #7 and #11). Findings include: Resident #7 Resident #7 was admitted to the facility on 08/14/2019, with diagnoses including mild cognitive impairment, memory deficit and dementia. Resident #7's clinical record documented a physical exam completed on 05/05/2023. Resident #7's clinical record lacked documented evidence of a physical exam completed for 2024. On 08/07/2024 at 11:30 AM, the Wellness Director confirmed confirmed Resident #7 did not have an annual physical for 2024. Resident #11 Resident #11 was admitted to the facility on 05/17/2022, with diagnoses including dementia, atrial fibrillation, and type two diabetes. Resident #11's clinical record documented a physical exam completed on 04/04/2023. Resident #11's clinical record lacked documented evidence of a physical exam completed for 2024. On 08/07/2024 at 2:37 PM, the Wellness Director confirmed confirmed Resident #11 did not have an annual physical for 2024. Severity: 2 Scope: 1	0859	Residents #7 and #11 lacked documented evidence of a physical exam completed for 2024. On 08/26/2024, Resident #7 received the Physician's Annual Report. On 8/11/2024, Resident #11 received the Physician's Annual Report. We have implemented a tracking system that monitors due dates for all residents' physical exams and notifies the facility's nursing or administrative team 60 days before the exams are due. We will be conducting an in-service training for all relevant staff regarding these policies, focusing on the importance of timely scheduling and documentation of physical exams and review of systems. This training will be documented and monitored. The Wellness Director will conduct monthly audits of resident medical records to ensure that physical exams are completed and properly documented with the required time frame.	09/24/2024
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential	0870	Residents #6 and #7 lacked documentation regarding Pharmacy Review. On 3/26/2024, Resident #6 received a Pharmacy Review. On 8/6/2024, received a Pharmacy Review for 2024.	09/24/2024

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	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 paragraph (a). Inspector Comments: Based on interview, clinical record review, and document review, the Administrator failed to ensure a Pharmacy Review was completed at least once every six months for 2 of 15 sampled residents in the facility longer than six months (Resident #6 and #7). Findings include: Resident #6 Resident #6 was admitted to the facility on 07/06/2023, with diagnoses including essential hypertension, atrial fibrillation, and chronic heart failure. Resident #3's clinical record included a Pharmacy Review completed on 09/07/2023, but lacked a Pharmacy Review completed on or before 03/07/2024. Resident #7 Resident #7 was admitted to the facility on 08/14/2019, with diagnoses including mild cognitive impairment, memory deficit and dementia. Resident #7's clinical record included a Pharmacy Review completed on 09/06/2023, but lacked a Pharmacy Review completed on or before 03/06/2024. On 08/07/2024 at 2:30 PM, the Wellness Director confirmed Resident#6 and #7 did not have a six month Pharmacy Review prior to their due date in March 2024. Severity: 2 Scope: 1		On 8/6/2024, Resident #7 received a Pharmacy Review. Wellness Director and or designee will review the pharmacy Review process and include in monthly Quality Assurance meetings to review compliance data and discuss any necessary adjustments. Well Director and or designee will conduct weekly audits of resident admissions to ensure that pharmacy reviews are completed with 7 days for all new admissions. On September 24, 2024, Executive Director and or designee to monitor ongoing compliance via Quality Assurance meetings weekly x 2 weeks, every other week x 1 and monthly thereafter, if needed, until compliance is met.	
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 -	0878	On 8/13/2024, Resident #6 received a discontinued order for the Furosemide, take	09/24/2024

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	Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the		1 tablet by mouth once daily on Monday, Wednesday and Friday for combined systolic and Diastolic (Congestive) Heart Failure. We are implementing a change order tracking system that requires staff to log and track all physician and care plan change orders, including the date issued, dated completed, and the staff responsible for executing them. A reminder system will be added to alert staff if an order is nearing its completion deadline. We will be conducting mandatory training sessions for nursing and administrative staff on the policies and procedures related to change orders. In conducting an in-service we will ensure that all staff understand their role in completing and documenting change orders with the required timeframes.	

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	record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, clinical record review, document review, and interview, the facility failed to ensure a medication had an order change sticker affixed to the label when a new order was received for 1 of 15 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 07/06/2023, with diagnoses including essential hypertension, atrial fibrillation and chronic heart failure. On 08/07/2024, during a review of medications for Resident #6, the resident's Furosemide 20 milligram (mg) container, documented take one tablet by mouth once daily. Resident #6's Medication Administration Record dated August 1, 2024 through August 31, 2024 (August 2024), and a physician's order dated 05/10/2024, documented Furosemide 20 mg, take one tablet by mouth once daily on Monday, Wednesday and Friday. On 08/07/2024 at 1:35 PM, the Medication Technician confirmed the label on Resident #6's Furosemide was not the same as the physician's order and verbalized the container should have an order change sticker affixed the the label. On 08/07/2024 at 2:19 PM, the Wellness Director verbalized resident medications with a physician's order change where the medication can still be used should have an order change sticker affixed the the label. Severity: 2 Scope: 1			
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.	0885	On 8/15/2024, Resident #5 discontinued medications were destroyed: Omeprozole oral capsule delayed release 20 milligrmas, take one capsule by mouth once daily before breakfast. Amlodipine tablet 5 milligrams, take one tablet by mouth once daily. Potassium Chloride tablet 20 MEQ ER, take two tablets (40 MEQ) by mouth once daily. On 8/16/2024, Resident #15 discontinued medications were destroyed: Amlodipine tablet 5 mg, take one tablet by mouth once daily. On 8/15/2024, Resident #8 discontinued medications were destroyed: Donepezil	09/24/2024

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	Inspector Comments: Based on observation, interview, clinical record review, and document review, the facility failed to ensure a discontinued medication was destroyed for 3 of 15 sampled residents (Resident #5, #15, and #8). Findings include: Resident #5 Resident #5 was admitted to the facility on 06/13/2024, with diagnoses including malignant neoplasm of colon, epilepsy and recurrent seizures, dysphagia. On 08/07/2024, during a review of medications for Resident #5, the following medication was stored in the drawer with the resident's medication: - Omeprazole oral capsule delayed release 20 milligrams (mg), take one capsule by mouth once daily before breakfast. Physician Order dated 06/12/2024, documented the prescription for Omeprazole oral capsule delayed release 20 mg capsule was to be discontinued. On 08/07/2024 at 1:29 PM, the Medication Technician verbalized the Omeprazole 20 mg capsule should have been destroyed when the physician ordered to discontinue the medication was received. - Amlodipine tablet 5 mg, take one tablet by mouth once daily. Physician Order dated 06/12/2024, documented the prescription for Amlodipine 5 mg tablet was to be discontinued On 08/07/2024 at 1:29 PM, the Medication Technician verbalized the Amlodipine 5 mg tablet should have been destroyed when the physician order to discontinue the medication was received. - Potassium Chloride tablet 20 MEQ ER, take two tablets (40 MEQ) by mouth once daily. Physician order dated 06/12/2024, documented the prescription for Potassium Chloride tablet 20 MEQ ER tablet was to be discontinued. On 08/07/2024 at 1:29 PM, the Medication Technician verbalized the Potassium Chloride tablet 20 MEQ ER tablet should have been destroyed when the physician order to discontinue the medication was received. The Medication Technician confirmed the discontinued medication card should have been removed from the medication cart and destroyed. Resident #15 Resident #15 was admitted to the facility on 12/11/2023, with diagnoses including dementia, hyperlipidemia, and		HCL 10 md, take 1/2 tablet (5mg) by mouth at bedtime for seven nights, then one tablet at bedtime. Wellness Director and or designee to conduct weekly audits for the next three months to review the medication destruction log and ensure that all discontinued medications are destroyed within the required timeframe. Ongoing monitoring after the inital audit period, monthly audits will continue for the next six months as part of the Quality Assurance program. Any discrepancies or delays in the destruction will be addressed immediately.	

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	hypertension. On 08/07/2024, during a review of medications for Resident #15, the following medication was stored in the drawer with the resident's medication: - Amlodipine tablet 5 mg, take one tablet by mouth once daily. A Physician Order dated 07/12/2024 with a stop date of 08/06/2024, documented the prescription for Amlodipine 5 mg tablet was to be discontinued On 08/07/2024 at 2:32 PM, the Medication Technician verbalized the Amlodipine 5 mg tablet should have been destroyed when the physician order to discontinue the medication was received. Resident #8 Resident #8 was admitted to the facility on 04/12/2024, with diagnoses including osteoporosis, osteoarthritis, frailty and right ankle fracture. On 08/07/2024, during a review of medications for Resident #8, the resident's Donepezil HCL 10 mg, take 1/2 tablet (5 mg) by mouth at bedtime for seven nights, then one tablet at bedtime, was stored in the drawer with the resident's medications. A Physician's order dated 07/16/2024, documented the prescription for Donepezil was to be discontinued. On 08/07/2024 at 2:06 PM, the Medication Technician (MT) verbalized the Donepezil 10 mg tablet should have been destroyed when the physician order to discontinue the medication was received. The MT verbalized the medication could mistakenly be administered to the resident while still in the medication cart after the physician's order to discontinue. On 08/07/2024 at 2:19 PM, the Wellness Director verbalized discontinued or expired medications should be immediately pulled from the medication cart and destroyed using the destruction liquid container or by mixing with kitty litter. The destruction containers were kept in the medication room. Severity: 2 Scope: 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 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	0895	On 8/6/2024, Resident #7 received physician's orders for the Lidocaine pad 5%, apply to the skin on the lower back every 24 hours as needed for pain. (12 hours on 12 hours off). On 8/6/2024, Resident #7 received physician's orders on administering Acetaminophe Tab 325 mg, take 1 tablet by mouth twice daily as needed for general pain.	09/24/2024

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	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; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on observation, clinical record review, document review, and interview, the facility failed to ensure as needed medications had symptom(s) being treated documented on the Medication Administration Record (MAR) for 1 of 15 sampled residents with medications reviewed Resident #7. Findings include: Resident #7 Resident #7 was admitted to the facility on 08/14/2019, with diagnoses including mild cognitive impairment, memory deficit, essential tremor and dementia. Resident #7's MAR dated August 1, 2024 through August 31, 2024 (August 2024), and medication containers labels documented the following medications: - Acetaminophen 325 milligrams (mg), take one tablet by mouth twice daily as needed. - Lidocaine Pad 5%, apply one patch every 24 hours as needed (12 hours on and 12 hours off). A physician's order dated 07/19/2024, documented the following: - Acetaminophen 325 mg, take one tablet by mouth every day for mild pain. - Lidocaine 5% topical patch, apply one patch every 24 hours as needed for pain (12 hours on and 12 hours off). On 08/07/2024 at 1:51 PM, the Medication Technician confirmed Resident #6's MAR and medication container labels lacked the symptoms for administering the Acetaminophen and Lidocaine and		We will be documenting symptoms being treated with PRN medications. The policy will specify that the symptoms must be recorded at the time of administration and staff must assess and document the resident's response to the medication. We will provide an in-service training for medication technicians on the revised PRN medication documentation procedures. Wellness Director and or designee will continue to monitor the MARs daily to ensure that the PRN medications are documented properly with the resident's response to the PRN medications to ensure effective care and regulatory compliance.	

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SIERRA PLACE RETIREMENT COMMUNITY	**1111 W COLLEGE PARKWAY, CARSON CITY, NEVADA ,89703**

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	verbalized there should have been a symptom for giving the medications. On 08/07/2024 at 2:20 PM, the Wellness Director verbalized all as needed (PRN) medications require a symptom for administering the medication and the resident's MAR and medication label should identify the symptom for administering the medication. Severity: 2 Scope: 1			
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, clinical record review and interview, the facility failed to ensure 1 of 15 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 07/08/2024, with diagnoses including hyperlipidemia, insomnia, malnutrition, hypertension, and mild dementia. Resident #4's clinical record contained an initial TB test administered on 06/29/2024. The TB test lacked a read date. The clinical record lacked documented evidence a second step TB test was completed. On 08/07/2024 at 1:44 PM, the Wellness Director confirmed the initial TB test lacked a read date and a second step TB test had not been completed. Severity: 2 Scope: 1	0936	On 8/21/2024 and 8/28/2024, Resident #4 received her 2 step TB testing. Ensure that all new residents are screened for TB upon admission and the annual TB tests are scheduled and completed for all residents. We have implemented a tracking system that monitors due dates for all residents' TB testing and notifies the Wellness Director and or designee 60 days before the exams are due. TB screening and testing process has been integrated into the admission checklist for new residents, and verify that all TB tests are completed within the required timeframe before residents are admitted into the general population.	09/24/2024
1600 SS= C	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and	1600	On 8/10/2024, Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15 are in compliance with R016-20 Section 19. We have implemented a section of the Move In Record to reflect a resident's	09/24/2024

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	in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics		preferred name, pronouns, gender identity or expressions of resident, and sexual orientation. Updated the admission process that will take place when gathering this information upon admission, updating it as needed, and ensuring that all staff are aware of residents' preferences. Reviewing and updating this information annually during the care planning process or whenever the resident expresses a change in their preferred pronouns. Providing an in-service sensitivity training on gender identity and pronoun usage with instructions on how to update records and the steps to take if a resident wished to change their pronouns. Emphasizing the importance of respecting residents' dignity and rights as part of individualized, person centered care.	

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	of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure there were policies developed and resident records in compliance with R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 62 of 62 residents. Findings include: On 08/07/2024 in the morning, the 15 sampled resident clinical records reviewed, Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15, lacked documentation to be in compliance with R016-20 Section 19. On 08/07/2024 at 11:12 AM, the Executive Director confirmed there were no updated policies or changes to resident clinical records in compliance with the regulation. Severity: 1 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the	1700	On 8/26/2024, Resident #7 we received the Physicians Annual Report with Placement Determination. On 8/21/2024, Resident #10 we received the Physicians Annual Report with Placement Determination. On 8/11/2024, Resident #11 we received the Physicians Annual Report and Determination with Placement Determination. We have implemented a tracking system that monitors due dates for all residents' Physician's Annual Report and notifies the Wellness Director and or designee 60 days before the exams are due. The system will include alerts to notify Wellness Director and or designee 60 days	09/24/2024

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	immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the facility failed to obtain an annual Standard Physician Assessment and Placement Determinations for 3 of 15 sampled residents with a diagnosis of dementia (Resident #7, #10, and #11). Findings include: Resident #7 Resident #7 was admitted to the facility on 08/14/2019, with a diagnosis of dementia. Resident #7's clinical record documented a Standard Placement Determination dated 05/05/2023. The clinical record lacked documented evidence of an annual Standard Placement		before assessments are due and track whether the assessment and placement determinations have been completed. Working closely with attending physicians to develop a system for coordinating physician's annual visits for a timely process. This will involve setting up standing appointments for the entire year.	

Division of Public and Behavioral Health

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	Determination for 2024. Resident #10 Resident #10 was admitted to the facility on 08/14/2023, with a diagnosis of dementia. Resident #10's clinical record documented a Standard Placement Determination dated 07/31/2023. The clinical record lacked documented evidence of an annual Standard Placement Determination for 2024. On 08/07/2024 at 11:30 AM, the Wellness Director confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #7 and #10 for 2024 and verbalized not knowing the document had to be completed annually for residents with a dementia diagnosis. Resident #11 Resident #11 was admitted to the facility on 05/17/2022, with diagnoses including dementia, atrial fibrillation, and type two diabetes. Resident #11's clinical record documented a Standard Placement Determination dated 04/04/2023. The clinical record lacked documented evidence of an annual Standard Placement Determination for 2024. On 08/07/2024 at 2:27 PM, the Wellness Director confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #11 for 2024 and verbalized not knowing the document had to be completed annually for residents with a dementia diagnosis. Severity: 2 Scope: 1			

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1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on personnel file review and interview, the primary and secondary infection control staff failed to complete the required 15 hours of infection control training (Employee #2 and #3). Findings include: Employee #2 Employee #2 was hired by the facility as the Executive Director with a start date of 01/31/2023. Employee #2's personnel file lacked documented evidence 15 hours of infection control training had been completed. Employee #3 Employee #3 was hired by the facility as the Wellness Director with a start date of 01/25/2023. Employee #3's personnel file lacked documented evidence 15 hours of infection control training had been completed. On 08/07/2024 at 11:52 AM, the Executive Director verbalized Employee #3 and the Executive Director (Employee #2) were the primary and secondary infection control staff. The Executive Director confirmed the initial infection control training was not completed. Severity: 2 Scope: 3	1830	On 9/11/2024, Employee #2 completed the Infection Control Required Training. On 9/26/2024, Employee #3 completed the Infection Control Required Training. We have added the annual 15 hours of Infection Control Training to our employee survey manifest. This process will help us monitor and track the training status of infection control staff to ensure compliance at all times. The system should automatically alert the Wellness Director when infection control staff members are approaching the required 15-hour training deadline or if they have not completed the required hours.	09/24/2024