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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**02/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF SPARKS	**2360 WINGFIELD HILLS DR, SPARKS, NEVADA ,89436**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted at your facility on 02/09/23. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 112 Residential Facility for Group with 80 beds which provide assisted living services for elderly and disabled persons and/or persons with chronic illnesses and 32 beds for person's with Alzheimer's disease, Category II residents. The census at the time of the survey was 68. Fifteen resident files were reviewed and 20 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. Complaint #NV00067725 with the following allegations could not be substantiated due to lack of evidence: Allegation #1: Medication Technicians (MT) were pre-popping and pre-labeling pills for multiple residents. Allegation #2: Call lights were not answered. Allegation #3: A resident died while a caregiver sat outside the resident room on their phone. Allegation #4: An MT stole liquid morphine by cutting the morphine with water. Investigation into the allegations included: Observation of staff administering medications, staff	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: SALVADOR GOMEZ-OROZCO | Title: Executive Director | Date: 04/19/2023

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	responding to call lights, staff providing assistance to residents. An audit of liquid medications was conducted. Interviews were conducted with six residents, one Care Manager, five Medication Technicians/Care Managers, the Wellness Director, and the Executive Director. Record review included physician orders, hospice orders, Medication Administration Records, and the narcotic count. Facility policy review included Medication Administration: Controlled Substances Policy and Procedure and Medication Count: Controlled Substances Policy and Procedure. 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 regulatory deficiencies were identified:			

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0994 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure dangerous items were inaccessible to residents housed in the memory care unit for 3 of 19 occupied rooms (Room #18, #1, and #10). Findings include: On 02/09/23, the following resident rooms contained unsecured dangerous items: On 02/09/23 at 09:23 AM, Room 18 contained the following unsecured dangerous item: - an electric fireplace On 02/09/23 at 10:30 AM, Room 1 contained the following unsecured dangerous item: - a stapler with staples inside On 02/09/23 at 10:45 AM, Room 10 contained the following unsecured dangerous item: - a push pin in the wall On 02/09/23 at 09:23 AM through 10:45 AM, the Regional Director of Maintenance and/or Maintenance Director confirmed the items found were dangerous and should be secured. The facility policy titled "Safety Reflections Protocol," revised July 2021, documented resident suites must be free of chemicals, items labeled "keep out of reach of children," items known to be potentially hazardous, knives, or other sharp instruments and medications. This was a repeat deficiency from the 01/24/22 annual re-licensure survey. Severity: 2 Scope: 1	0994	Executive Directorwith support of unit manager and Wellness Director will ensure items prohibitedin memory are properly secured in locked drawers/cabinets. Wellness Director toperform routine audits. Unit manager will provide re-training to team and perform routine room sweeps.	03/01/2023
0999 SS= E	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS	0999	Executive Directorwith support of unit manager and Wellness Director will ensure items prohibitedincluding anything marked as "keep out of	03/01/2023

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	449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents housed in the memory care unit for 4 of 19 occupied rooms. Findings include: On 02/09/23 at 09:15 AM, Room 19 contained the following unsecured toxic substances: - two 8.2-ounce tubes of Crest adult toothpaste - a 3.5-ounce container of Ban powder fresh roll-on deodorant - a 2-ounce container of Purell advanced hand sanitizer - a 0.5-ounce container of Clinique Even Better correcting moisturizer - a 5.5-ounce container of Soft Soap soothing aloe vera hand soap On 02/09/23 at 10:15 AM, Room 2 contained the following unsecured toxic substances: - an 8-ounce container of Dermasil dry skin treatment - three face powder compacts - a 0.6-ounce tube of Ultra Brite advanced whitening toothpaste - a container of Maybelline eye shadow - a 0.5-ounce container of Clear Eyes redness relief - two 0.5-ounce containers of Neosporin - a 0.5-ounce container of Bausch & Lomb advanced eye relief - a bar of Dove soap - two hotel-size bars of soap from Howard Johnson's On 02/09/23 at 10:37 AM, Room 7 contained the following unsecured toxic substances: - a 0.15-ounce tube of Maybelline lipstick - a Loreal brow stylist definer pencil On 02/09/23 at 10:57 AM, Room 14 contained the following unsecured toxic substances: - a 3.4-ounce container of Paradontax active gum repair - a 9.5-ounce container of Paul Mitchell firm style hair spray - a 5.5-ounce container of Gold Bond ultimate shea butter On 02/09/23 at 09:15 AM through 10:57 AM, the Regional Director of Maintenance and/or the Maintenance Director confirmed the presence of unsecured toxic substances in rooms #19, #2, #7, and #14. The facility		reach of children" inmemory are properly secured in locked drawers/cabinets. Wellness Director toperform routine audits.	

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	policy titled "Safety Reflections Protocol," revised July 2021, documented resident suites must be free of chemicals, items labeled "keep out of reach of children," items known to be potentially hazardous, knives, or other sharp instruments and medications. Severity: 2 Scope: 2			

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1305 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. Inspector Comments: Based on observation and interview, the facility failed to post a current nondiscrimination statement prominently in the facility and include on any Internet website used to market the facility. Findings include: On 02/09/23 at 11:14 AM, the facility lacked a current nondiscrimination statement for residents and the public to view. On 01/24/23 at 1:09 PM, the Admissions and Office Manager acknowledged the nondiscrimination statement posted did not contain the required language. Severity: 1 Scope: 3	1305	Executive Director toensure nondiscrimation statement is posted and maintained prominently for allresidents and visitors to facility to view. Executive Director will also ensurefacility's website is updated to contain the approved nondiscriminationstatement as well.	04/24/2023

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1310 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. (Added to NRS by 2019, 1333, effective January 1, 2020) Inspector Comments: Based on observation and interview, the facility failed to post prominently in the facility the State contact information to file a complaint for a resident who may have experienced prohibited discrimination. Findings include: On 02/09/23 at 11:14 AM, the facility lacked posted documentation of the State contact information to file a complaint for any resident who may experience discrimination. On 02/09/23 at 11:14 AM, the Director of Hospitality acknowledged the State's contact information had not been	1310	Executive Director toensure contact information for state health department is posted and maintainedprominently for all residents and visitors to facility to view.	03/01/2023

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	posted in any common public area of the facility to inform residents where to file a complaint of discrimination. Severity: 1 Scope: 3			
0072 SS= D	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 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 interview and employee record review, the facility failed to ensure 2 of 9 sampled employees who administered medication received at least eight hours of Medication Management training annually (Employee #16 and #18). Findings include: On 02/09/23, the Admissions and Office Manager was provided the Personnel Check List to complete for 20 sampled employees. On 02/09/23, the Admissions and Office Manager provided the completed form with the following information: Employee #16 Employee #16 was hired by	0072	Business OfficeManager to review employee records monthly to ensure annual med training iscompleted ahead of expiration dates. Executive Director to monitor throughmonthly business office QA.	03/01/2023

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	the facility as Medication Technician with a start date of 12/01/13. On 02/09/23, Employee #16's personnel file contained a medication management training dated 08/20/20 and a medication management training dated 06/24/21; however, the personnel file lacked annual medication management training for 2022. Employee #18 Employee #18 was hired by the facility as Medication Technician with a start date of 12/01/13. On 02/09/23, Employee #18's personnel file contained a medication management training dated 10/15/21 and a medication management training dated 01/13/23; however, the personnel file lacked annual medication management training for 2022. On 02/09/23 in the afternoon, the Admissions and Office Manager provided the Attestation of Compliance form, signed and dated 02/09/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this	0074	Business Office Manager to review employee records monthlyto ensure annual elder abuse training is completed ahead of expiration dates. ExecutiveDirector to monitor through monthly business office QA.	03/01/2023

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	subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any			

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	changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and employee record review, the facility failed to ensure 2 of 9 sampled employees who administered medication received at least eight hours of Medication			

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	Management training annually (Employee #16 and #18). Findings include: On 02/09/23, the Admissions and Office Manager was provided the Personnel Check List to complete for 20 sampled employees. On 02/09/23, the Admissions and Office Manager provided the completed form with the following information: Employee #16 Employee #16 was hired by the facility as Medication Technician with a start date of 12/01/13. On 02/09/23, Employee #16's personnel file contained a medication management training dated 06/24/21; however, the personnel file lacked annual medication management training for 2022. Employee #18 Employee #18 was hired by the facility as Medication Technician with a start date of 12/01/13. On 02/09/23, Employee #18's personnel file contained a medication management training dated 10/15/21 and a medication management training dated 01/13/23; however, the personnel file lacked annual medication management training for 2022. On 02/09/23 in the afternoon, the Admissions and Office Manager provided the Attestation of Compliance form, signed and dated 02/09/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
1700 SS= E	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;	1700	Wellness Director toensure physician placement determination statements are collected annually foreach resident. Executive Director to monitor through QA.	05/03/2023

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	(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 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 record review and interview, the facility failed to obtain an initial and/or an annual Physician Placement Determination Statement to			

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		A. BUILDING _____ B. WING _____	**02/09/2023**

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	determine the appropriate facility type and care for a resident for 6 of 15 sampled residents (Resident #1, #7, #9, #12, #15, and #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/27/20, with diagnoses including Alzheimer's disease and dementia. Resident #1's record documented a completed Physician Placement Determination Statement dated 12/08/20. Resident #1's record lacked documented evidence a Physician Placement Determination Statement had been completed in 2021 or 2022. Resident #7 Resident #7 was admitted to the facility on 10/19/20, with diagnoses including Alzheimer's disease and chronic kidney disease. Resident #7's record documented a Physician Placement Determination Statement dated 10/15/20. Resident #7's record lacked documented evidence a Physician Placement Determination Statement had been completed in 2021 or 2022. Resident #9 Resident #9 was admitted to the facility on 11/02/21, with diagnoses including dementia and type II diabetes mellitus. Resident #9's record documented a Physician Placement Determination Statement dated 10/28/21. Resident #9's record lacked documented evidence a Physician Placement Determination Statement had been completed in 2022. Resident #12 Resident #12 was admitted to the facility on 10/05/22, with diagnoses including atrial fibrillation, shortness of breath and anemia. Resident #12's record lacked documented evidence a Physician Placement Determination Statement had been completed upon admission of the resident to the facility. Resident #15 Resident #15 was admitted to the facility on 02/03/20, with diagnoses including Alzheimer's disease, hypotension and hypothyroidism. Resident #15's record lacked documented evidence a Physician Placement Determination Statement had been completed since admission of the resident to the facility. On 02/09/23 at 4:02			

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	PM, the Wellness Director verbalized the facility would only have completed a Physician Placement Determination Statement for a resident upon admission or if a change of condition. The Wellness Director confirmed the Physician Placement Determination Statements had not been completed in 2021 and 2022 for Resident's #1, #7 and #9, and had not been completed upon or since admission for Resident's #12 and #15. The Wellness Director verbalized not having been aware of the annual requirement for a Physician Placement Determination Statement. Resident #3 Resident #3 was admitted to the facility on 01/06/22, with diagnoses including diabetes, obesity, and anemia. Resident #3's record lacked documented evidence a Physician Placement Determination Statement had been completed upon admission of the resident to the facility. On 02/09/23 at 4:10 PM, the Wellness Director verbalized the facility would only have completed a Physician Placement Determination Statement for a resident upon admission or if a change of condition. The Wellness Director confirmed the Physician Placement Determination Statements had not been completed for resident #3. Severity: 2 Scope: 2			

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 20 employees met the requirements concerning tuberculosis (TB) testing. (Employee #) Findings include: On 02/09/23, the Admissions and Office Manager was provided the Personnel Check List to complete for 20 sampled employees. On 02/09/23, the Admissions and Office Manager provided the completed form with the following information: Employee #3 Employee #3 was hired by the facility as Administrator, with a start date of 07/20/21. The personnel record for Employee #3 contained a Quantiferon TB test on 09/16/21. The facility was unable to provide documented evidence of Employee #3's annual 2022 TB test. Employee #21 Employee #21 was hired by the facility as a Care Manager, with a start date of 12/06/21. The personnel record for Employee #21 contained a Quantiferon TB test on 12/04/21 and a Quantiferon TB test on 01/17/23. Additionally, the facility was unable to provide documented evidence of Employee #21's annual 2022 TB test. On 02/09/23 in the afternoon, the Admissions and Office Manager provided the Attestation of Compliance form, signed and dated 02/09/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0102	Business officemanager to ensure employee tb records are correct and up to date includinghaving team members undergo tb testing prior to physically starting incommunity and annually. Executive Director to monitor through QA.	03/01/2023

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

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0178 SS= E	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview the facility failed to ensure the dryer lint trap was free from excessive lint. Findings include: On 02/09/23 at 9:15 AM, a dryer in the Memory Care unit contained a thick layer of lint on the lint trap. On 02/09/23 at 9:15 AM, the Regional Director of Maintenance confirmed the lint trap contained excessive lint. Severity: 2 Scope: 2	0178	Maintenance Directorto ensure dryers are kept free of excessive lint. Executive Director to monitorthrough QA.	03/01/2023
0321 SS= D	Bedroom Doors - Single Motion Locks - NAC 449.220 Bedroom doors. (NRS 449.0302) 2. A bedroom door must not be equipped with a deadbolt lock or chain stop unless the door opens directly to the outside of the facility. The doors of a bedroom and the doors of the closets in the bedroom may be equipped with locks for use by residents if: (a) The doors may be unlocked with a single motion from inside the bedroom or closet without the use of a key; and (b) The doors of the bedroom may be unlocked from outside the room and the keys are readily available at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure resident room doors were equipped with single motion locks. Findings include: On 02/09/23 at 10:28 AM, Room 5's corridor door and Room 4's corridor door contained double-motion locks. On 02/09/23 at 10:28 AM, Regional Director of Maintenance confirmed two motions were required to open the doors if they were locked. Severity: 2 Scope: 1	0321	Maintenance Directorto ensure all resident apartment doors utilize single motion locks. ExecutiveDirector to monitor through QA.	03/01/2023
0620 SS= F	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4.	0620	WellnessDirector and Executive Director will ensure any residents	05/03/2023

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	Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 14 of 14 residents receiving skilled nursing services (Resident #1, #5, #7, #8, #13, #14, #15, #16, #17, #18, #19, #20, #21, and #22). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/27/20, with a diagnosis of senile degeneration of the brain. Resident #5 Resident #5 was admitted to the facility on 12/28/19, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #7 Resident #7 was admitted to the facility on 10/19/20, with diagnoses including unspecified dementia without behavioral disturbance and Alzheimer's disease. Resident #8 Resident #8 was admitted to the facility on 09/27/22, with a diagnosis of cerebral atherosclerosis. Resident #13 Resident #13 was admitted to the facility on 04/22/21, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #14 Resident #14 was admitted to the facility on 10/26/22, with a diagnosis of vascular dementia. Resident #15 Resident #15 was admitted to the facility on 02/03/20, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #16 Resident #16 was admitted to the facility on 02/03/20, with a diagnosis of end stage dementia. Resident #17 Resident #17 was admitted to the facility on 02/03/20, with a diagnosis of end stage dementia. Resident #18 Resident #18 was admitted to the facility on 12/08/21, with diagnosis including Alzheimer's disease and unspecified dementia without		that are in need ofhome health or hospice services have a waiver submitted for them for approvalfrom state health dept.	

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	behavioral disturbance. Resident #19 Resident #19 was admitted to the facility on 06/22/22, with a diagnosis of Alzheimer's disease. Resident #20 Resident #20 was admitted to the facility on 04/22/21, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #21 Resident #21 was admitted to the facility on an unknown date, with a diagnosis of senile degeneration of the brain. Resident #22 Resident #22 was admitted to the facility on 05/24/22, with a diagnosis of cerebral atherosclerosis. On 02/09/23 at 4:05 PM, the Wellness Director verbalized the facility had residents receiving 24 hour skilled nursing care through home health and hospice agencies. The Wellness Director explained the Wellness Director was not aware of the requirement to submit waivers to the State Agency for residents receiving 24 hour skilled nursing care. The Wellness Director confirmed the facility had not submitted waivers to the State Agency to retain residents receiving 24 hour skilled nursing care. Severity: 2 Scope: 3			
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking	0690	Wellness Director andunit managers to ensure oxygen tanks are properly secured in approvedreceptacles. Executive Director to monitor through QA.	03/01/2023

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	and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 02/09/23 at 12:08 PM, Room 230 contained five small oxygen cylinders. Three cylinders were secured in a box intended to secure oxygen. Two cylinders were placed unsecured on the floor next to the box. On 02/09/23 at 12:08 PM, the Regional Director of Maintenance (RDM) confirmed the oxygen tanks were unsecured and verbalized oxygen tanks should be kept secured. The RDM placed one unsecured cylinder in the box. The RDM verbalized there was no other way to secure the one unsecured oxygen cylinder. The RDM placed the unsecured oxygen cylinder in the Chart Room. The facility policy titled "Oxygen Policy & Procedure," revised January 2020, documented, "3. Ensure that all oxygen tanks (empty or full) are stored in a secure upright position in the resident's apartment or storage closet that is approved by the fire marshal." Severity: 2 Scope: 1			

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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 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 and clinical record review, the facility failed to ensure a resident admitted for six months or greater had a review of medications for accuracy and appropriateness for 1 of 15 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 10/06/21, with diagnoses including essential (primary) hypertension and lymphedema, not elsewhere classified. Resident #6's clinical record included a medication review completed on 01/10/23. The review was due to be completed no later than 04/06/22, and subsequently every six months. Severity: 2 Scope: 1	0870	Wellness Director toensure a pharmacy review occurs for each resident at least once every 6 months.Executive Director to monitor through QA.	03/01/2023
0871 SS= D	Medication Administration - Plan - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver	0871	Wellness Director andExecutive Director to work with hospice partners to ensure liquid	05/03/2023

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	and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician or other physician of the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training		narcoticmedications are kept current and implement measures to allow for more accuratetracking including utilizing syringes pre-filled by pharmacy.	

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	update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on observation, interview, clinical record review, and document review, the Executive Director failed to have a plan in place to reconcile liquid narcotic medications for 1 of 14 hospice residents (Resident #16). Findings include: During an audit of liquid pain and anxiety medications on the medication carts, a discrepancy in medication amounts was discovered. Resident #16's medication bottle for morphine concentrate showed an amount of 16.25 milliliter (ml) of medication in the bottle. The medication box had a post-it note taped to the side: 18.75 01/17 18.5 01/18 18. 25 01/19 18.0 01/23 17.75 02/01 17.5 02/02 17.25 02/05 17.0 02/06 16.75 02/06 On 02/09/23 at 10:24 AM, Medication Technician 1 (MT1) verbalized the MT1 administered liquid morphine and lorazepam to hospice residents. The MT1 explained the liquid morphine was received in 30 ml containers. The MT1 used a syringe to draw up the dose of liquid medication to administer to the resident. The MT1 verbalized the MT1 wrote the remaining amount of medication and the date administered on post-it note. At shift change, the MT1 entered the amount of medication left listed on the post-it note into the system for the narcotic count. The MT1 verbalized the morphine bottle for Resident #16 appeared to have approximately 16.25 ml of medication in the bottle. The MT1 confirmed the bottle did not appear to contain 16.75 ml of medication in the bottle and there was a discrepancy between the amount of medication in the bottle and the handwritten amount documented on the post-it note on the side of the medication box. On 02/09/23 at 11:10 AM, the Wellness Director verbalized the morphine bottle for Resident #16 appeared to have a little over			

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	16 ml of medication left in the bottle. The Wellness Director confirmed the post it note on the medication box documented the amount of medication left in the bottle as 16.75 ml. The Wellness Director explained the bottle contained more than 16 ml and less than 20 ml of medication and the Wellness Director was unable to determine there was a discrepancy because the bottle had hashmarks for 16 ml and 20 ml, and lacked a hashmark for 17 ml. The Wellness Director verbalized to consider the Medication Technicians draw the medication up into a syringe and that could account for the discrepancy. The Wellness Director explained discrepancies in medication would be reported to the Wellness Director and the Wellness Director would conduct an investigation to determine the cause of the discrepancy. The investigation would include interviewing the Medication Technician, reviewing the Medication Administration Record (MAR), and notifying the physician and hospice agency. The Wellness Director was unable to articulate how the Wellness Director could determine if medication was missing based on the actual medication left in the container versus the amount of medication documented in the narcotic count if the Wellness director was unable to determine how much medication was in the container, since the container only had hash marks for every 4 milliliters and no hash marks in between. On 02/09/23 at 11:20 AM, the Executive Director, during a phone call, verbalized Medication Technicians conduct a blind narcotic count. The Medication Technician would enter the amount of medication left in the bottle into the system. If the wrong amount was entered into the system twice, the system would automatically alert management. The Executive Director explained after the two failed entries, the Executive Director and the Wellness Director would conduct an investigation determine if a medication was missed or a medication spill occurred. The			

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(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
	Executive Director confirmed Medication Technicians draw the liquid medications up into a syringe and the discrepancy could be from using the syringe. The Executive Director verbalized, in the future, the facility could have hospice bring pre drawn syringes into the facility. Resident #16 Resident #16 was admitted to the facility on 02/03/20, with a diagnosis of end stage dementia. Resident #16's physician order dated 12/01/21, documented morphine concentrate 100 mg/5 ml. Take 0.25 ml by mouth every four hours as needed for breakthrough pain. Resident #16's January 2023 Medication Administration Record (MAR) documented: Morphine sulfate 0.25 ml was administered on 01/03/23, 01/04/23, 01/17/23 at 8:01 AM and 7:21 PM, 01/18/23, 01/19/23, and 01/23/23 for pain. Resident #16's February 2023 Medication Administration Record (MAR) documented: Morphine sulfate 0.25 ml was administered on 02/01/23, 02/02/23, 02/05/23, 02/06/23 at 10:44 AM and 2:27 PM, for pain. On 02/09/23 at 3:21 PM, the Wellness Director verbalized the facility policy lacked a procedure to reconcile liquid narcotic medications. The facility policy titled "Medication Administration: Controlled Substances Policy and Procedure," dated July 2021, documented all medications considered controlled substances or narcotics would be monitored and counted on each shift at a minimum. When there was a count discrepancy, immediate steps would be taken to resolve the error. The facility policy titled "Medication Count: Controlled Substances Policy and procedure," dated July 2021, documented the narcotic count would be completed using the inventory function within the electronic MAR system at the start of shift or whenever the team member in charge of the cart must leave the community grounds for any length of time. Compare the actual number of medication available in the bubble pack card or bottle with the actual number reflected remaining in the account.			

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		A. BUILDING _____ B. WING _____	**02/09/2023**

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	These numbers must match. The facility policy lacked instructions on reconciliation of liquid medications when a discrepancy was identified. Severity: 2 Scope: 1			
0905 SS= E	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 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 interview, clinical record review, and document review, the facility failed to ensure as needed (PRN) medications were only administered to residents that could verbalize their need for the medication and the specific symptom the medication was ordered to treat for 13 of 13 hospice residents with cognitive deficits (Resident #1, #3, #5, #7, #8, #13, #14, #15, #16, #17, #18, #19, #21, #22) and written instructions indicating the specific symptom(s) for which an PRN medication was to be given was documented for 2 of 15 sampled residents (Resident #13 and #3). Findings include: On 02/09/23 at 11:01 AM, Medication Technician 1 (MT1) verbalized residents residing in memory care were not able to verbalize their need for PRN medication due to cognitive impairment. The MT1 explained the MT1 looked at the resident's body language, facial expressions, activity levels, and agitation levels to determine the	0905	Wellness Director to ensure physician orders for residentsunable to verbalize their need for PRN medications have clear instructions fromphysician on what/how pain, anxiety, and/or agitation present in each resident.Executive Director to monitor through QA.	05/03/2023

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	need for the medication. The MT1 knows the residents and knows the medication were effective by looking at the resident's facial expressions to see if they were grimacing or still agitated. The MT1 confirmed orders for the PRN medications listed pain, anxiety, and/or agitation as a symptom, however, the orders did not specify what pain, anxiety, and/or agitation presented as in each resident. The MT1 verbalized the MT1 knew the residents in the memory care unit and knew what behaviors presented for pain, anxiety, and agitation in those residents. On 02/09/23 at 12:23 PM, Medication Technician 2 (MT2) verbalized the MT2 looked for signs of restlessness, agitation, anxiety, shortness of breath, groaning, facial movements, wincing, or grimacing when administering PRN pain and anxiety medications to residents that were cognitively impaired. The MT2 knows the pain or anxiety medication was effective by looking at the resident to determine the symptoms have resolved. The MT2 has not seen orders that breakdown what pain looked like specifically, however the MT2 knows what symptoms the residents presented with when they were in pain. On 02/09/23 at 3:14 PM, Medication Technician 3 (MT3) verbalized only the hospice residents receive morphine and not all hospice residents vocalize or act like they are in pain. The MT3 explained the MT3 had only one resident that was able to ask for pain medications. Those that did not vocalize their pain levels or act like they were in pain were not administered PRN pain medication. The MT3 explained the MT3 looked for pain symptoms such as the way the resident moved, wincing, moaning, and groaning. Resident #1 Resident #1 was admitted to the facility on 10/27/20, with a diagnosis of senile degeneration of the brain. Resident #1's physician order dated 12/28/22, documented lorazepam 2 milligram/ milliliter (mg/ml). Take 0.25 ml by mouth every two hours as needed for			

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	terminal agitation/anxiety. Resident #1's physician order dated 12/28/22, documented morphine sulfate 100 mg/5 ml. Take 0.25 ml by mouth every two hours as needed for pain or shortness of breath. Resident #1's physician order dated 11/16/22, documented quetiapine fumarate 25 mg tablet. Take one tablet by mouth every six hours as needed for anxiety. Resident #1's February 2023 Medication Administration Record (MAR) documented: Lorazepam 0.25 mg was administered on 02/03/23 for agitation/anxiety. Quetiapine fumarate 25 mg tablets was administered on 02/02/23, 02/03/23, 02/04/23, 02/05/23, and 02/07/23 for agitation. Resident #5 Resident #5 was admitted to the facility on 12/28/19, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #5's physician order dated 09/20/21, documented Ativan (lorazepam) 0.5 mg tablet. Take one tablet by mouth every two hours as needed for anxiety/shortness of breath. Resident #5's physician order dated 09/20/21, documented morphine sulfate 100 mg/5 ml. Take 0.25 ml by mouth every two hours as needed for pain and shortness of breath. Resident #5's February 2023 Medication Administration Record (MAR) documented: Lorazepam 0.5 mg tablet was administered on 02/08/23 for anxiety. Resident #7 Resident #7 was admitted to the facility on 10/19/20, with diagnoses including unspecified dementia without behavioral disturbance and Alzheimer's disease. Resident #7's physician order dated 11/03/22, documented lorazepam 2 mg/ml. Take 0.25 ml by mouth every two hours as needed for anxiety or shortness of breath. Resident #7's physician order dated 11/03/22, documented morphine concentrate 100 mg/5 ml. Take 0.25 ml by mouth every 30 minutes as needed for pain or shortness of breath. Resident #8 Resident #8 was admitted to the facility on 09/27/22, with a diagnosis of senile degeneration of the brain. Resident #8's			

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	physician order dated 11/08/22, documented Ativan (lorazepam) 0.5 mg tablet Take one tablet by mouth every four hours as needed for anxiety. Resident #8's physician order dated 11/03/22, documented morphine concentrate 20 mg/ml. Take 0.25 ml by mouth every two hours as needed for pain or shortness of breath. Resident #13 Resident #13 was admitted to the facility on 04/22/21, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #13's physician order dated 06/16/22, documented lorazepam 2 mg/ml. Take 0.25 ml by mouth every 30 minutes as needed. Resident #13's physician order dated 06/16/22, documented morphine concentrate 100 mg/5 ml. Take 0.25 ml by mouth every two hours as needed. Resident #13's January 2023 Medication Administration Record (MAR) documented: Morphine sulfate 0.25 ml was administered on 01/09/23 for knee and right arm pain, and 01/11/23 for body pain. Lorazepam 0.25 ml was administered on 01/24/23 at 6:54 AM and 01/24/23 at 7:40 PM for anxiety, 01/28/23, and 01/29/23 for anxiety. Resident #13's February 2023 Medication Administration Record (MAR) documented: Morphine sulfate 0.25 ml was administered on 02/01/23 for knee and left shoulder pain. Lorazepam 0.25 ml was administered on 02/02/23 for anxiety. Resident #14 Resident #14 was admitted to the facility on 10/26/22, with a diagnosis of vascular dementia. Resident #14's physician order dated 02/03/23, documented lorazepam 2 mg/ml. Take .25 ml by mouth every 30 minutes as needed for anxiety and nausea. Resident #14's physician order dated 02/03/23, documented morphine concentrate 100 mg/5 ml. Take 0.25 ml by mouth every 30 minutes as needed for pain or shortness of breath. Resident #15 Resident #15 was admitted to the facility on 02/03/20, with a diagnosis of unspecified dementia without behavioral disturbance. Resident #15's physician order dated 11/18/22,			

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	documented lorazepam 2 mg/ml. Take 0.25 ml by mouth every 30 minutes as needed for anxiety, nausea, agitation, or insomnia. Resident #15's physician order dated 11/18/22, documented morphine concentrate 100 mg/5 ml. Take 0.25 ml by mouth every two hours as needed for pain or shortness of breath. Resident #16 Resident #16 was admitted to the facility on 02/03/20, with a diagnosis of end stage dementia. Resident #16's physician order dated 12/01/21, documented lorazepam 0.5 mg tablet. Take one tablet by mouth every four hours as needed for anxiety, shortness of breath, and/or nausea. Resident #16's physician order dated 12/01/21, documented morphine concentrate 100 mg/5 ml. Take 0.25 ml by mouth every four hours as needed for breakthrough pain. Resident #16's January 2023 Medication Administration Record (MAR) documented: Morphine sulfate 0.25 ml was administered on 01/03/23, 01/04/23, 01/17/23 at 8:01 AM and 7:21 PM, 01/18/23, 01/19/23, and 01/23/23 for pain. Lorazepam 0.5 mg tablet was administered on 01/01/23 at 8:19 AM and 3:20 PM, 01/02/23, 01/03/23 at 8:08 AM and 4:35 PM, 01/04/23, 01/09/23, 01/10/23, 01/11/23, 01/12/23 at 7:53 AM and 4:41 PM, 01/13/23 at 7:52 AM and 5:00 PM, 01/16/23, 01/17/23, 01/18/23, 01/19/23, 01/21/23, 01/22/23, 01/23/23, 01/24/23, 01/25/23, 01/26/23, 01/29/23, 01/30/23, and 01/31/23 for agitation and anxiety. Resident #16's February 2023 Medication Administration Record (MAR) documented: Morphine sulfate 0.25 ml was administered on 02/01/23, 02/02/23, 02/05/23, 02/06/23 at 10:44 AM and 2:27 PM, for pain. Lorazepam 0.5 mg tablet was administered on 02/01/23 at 11:16 AM and 3:32 PM, 02/02/23, 02/05/23, 02/06/23 at 10:44 AM and 2:27 PM, and 02/07/23 for agitation. Resident #17 Resident #17 was admitted to the facility on 02/03/20, with a diagnosis of Alzheimer's disease. Resident #17's physician order dated 02/25/21, documented Ativan (lorazepam) 0.5 mg			

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	tablet. Take one tablet by mouth every two hours as needed for agitation or shortness of breath. Resident #17's physician order dated 02/25/21, documented morphine sulfate 100 mg/5 ml. Take 0.25 ml by mouth every two hours as needed for pain and shortness of breath. Resident #17's January 2023 Medication Administration Record (MAR) documented: Morphine 0.25 ml was administered on 01/02/23, 01/04/23, 01/05/23, 01/18/23, 01/21/23, and 01/23/23 for pain. Lorazepam 0.5 mg tablet was administered on 01/04/23 and 01/21/23 for anxiety. Resident #18 Resident #18 was admitted to the facility on 12/08/21, with diagnoses including Alzheimer's disease and unspecified dementia with behavioral disturbance. Resident #18's physician order dated 10/19/22, documented Ativan (lorazepam) 0.5 mg tablet. Take one tablet by mouth every two hours as needed for agitation or shortness of breath. Resident #18's physician order dated 10/19/22, documented morphine sulfate 100 mg/5 ml. Take 0.25 ml by mouth every two hours as needed for pain and shortness of breath. Resident #18's physician order dated 09/27/22, documented risperidone 0.25 mg tablet. Take one tablet by mouth three times daily as needed for agitation and increased behaviors. Resident #18's January 2023 Medication Administration Record (MAR) documented: Morphine 0.25 ml was administered on 01/2/23, 01/04/23, 01/10/23, 01/11/23, 01/13/23, 01/16/23, 01/17/23, 01/18/23, 01/19/23, 01/23/23, 01/29/23, 01/31/23 at 12:01 PM and 01/31/23 at 9:00 PM for pain. Lorazepam 0.5 mg tablet was administered on 01/01/23, 01/02/23, 01/08/23, 01/10/23, 01/11/23, 01/12/23 at 7:08 AM and 01/12/23 at 5:05 PM, 01/13/23 at 8:33 AM and 01/13/23 at 4:36 PM, 01/16/23, 01/17/23, 01/18/23, 01/19/23, 01/21/23, 01/23/23, 01/25/23, 01/29/23, 01/31/23 at 12:01 PM and 01/31/23 at 3:33 PM for agitation. Risperidone 0.25 mg tablet was administered 01/01/23, 01/02/23, 01/04/23,			

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	01/06/23, 01/07/23 at 8:33 AM and 01/07/23 at 4:31 PM, 01/11/23, 01/14/23, 01/15/23, 01/16/23, 01/18/23, 01/20/23, 01/21/23, 01/25/23, 01/27/23, 01/28/23, 01/29/23, 01/30/23, 01/31/23 at 11:26 AM and 01/31/23 at 3:53 PM for agitation. Resident #18's February 2023 Medication Administration Record (MAR) documented: Morphine 0.25 ml was administered on 02/01/23 and 02/05/23 for pain. Lorazepam 0.5 mg tablet was administered on 02/01/23, 02/02/23, 02/05/23, and 02/07/23 for agitation. Risperidone 0.25 mg tablet was administered on 02/03/23 and 02/04/23 for agitation. Resident #19 Resident #19 was admitted to the facility on 06/22/22, with a diagnosis of Alzheimer's disease. Resident #19's physician order dated 12/16/22, documented Haloperidol 0.5 mg tablet. Take one tablet by mouth daily as needed for increased agitation. Resident #19's physician order dated 02/05/23, documented Tramadol 50 mg tablet. Take one half or 25 mg tablet by mouth every six hours as needed for pain. Resident #19's February 2023 Medication Administration Record (MAR) documented: Tramadol 50 mg tablet, half tablet administered on 02/06/23 for pain. Tramadol 50 mg tablet, half tablet administered on 02/07/23 at 3:16 AM for "resident appears to be in pain." Tramadol 50 mg tablet, one tablet administered on 02/07/23 at 3:58 PM, for arm pain. Tramadol 50 mg tablet, one tablet administered on 02/08/23 at 2:07 PM and 02/08/23 at 9:36 PM for pain. Tramadol 50 mg tablet, one tablet administered on 02/09/23 for pain. Resident #21 Resident #21 was admitted to the facility with a diagnosis of senile degeneration of the brain. Resident #21's physician order dated 01/26/23, documented lorazepam 0.25 mg/ml. Take 0.25 ml by mouth every two hours as needed for breakthrough agitation/anxiety. Resident #21's January 2023 Medication Administration Record (MAR) documented: Lorazepam 0.25 ml administered on 01/29/23 for agitation.			

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	Resident #21's February 2023 Medication Administration Record (MAR) documented: Lorazepam 0.25 ml administered on 02/04/23 for agitation. Resident #22 Resident #22 was admitted to the facility on 05/24/22, with a diagnosis of senile degeneration of the brain. Resident #22's physician order dated 12/27/22, documented lorazepam 0.25 mg/ml. Take 0.25 ml by mouth every 30 minutes as needed for anxiety or shortness of breath. Resident #22's physician order dated 12/27/22, documented morphine 100 mg/5 ml. Take 0.25 ml by mouth every 30 minutes as needed for pain. On 02/09/23 a 12:40 PM, the Wellness Director verbalized Medication Technicians (MT) were not able to assess residents. The Wellness Director explained MTs were able to tell when a non-verbal resident needed a PRN pain medication based on their observation of the resident. The MTs observe how the resident was behaving or if they were presenting in pain: wincing or grimacing. The MTs administer pain medication based on their observations of the residents. Resident #13 Resident #13 was admitted to the facility on 04/22/21, with diagnoses including hypertension, hypothyroidism, and iron deficiency anemia. The February 2023 Medication Administration Record (MAR) for Resident #13 documented the following: - lorazepam intensol 2 milligrams (mg)/milliliters (ml), give 0.25 ml by mouth every two hours as needed. The lorazepam had been administered on 02/02/23 at 4:49 AM. - morphine sulfate 100 mg/5 ml concentrate, give 0.25 ml by mouth every two hours as needed. The morphine had been administered on 02/01/23 at 10:28 AM. On 02/09/23 at 1:32 PM, a Medication Technician confirmed the MAR for Resident #13 did not include a reason to give the as needed medications. On 02/09/23 at 3:58 PM, the Wellness Director verbalized the Medication Technicians were not able to assess residents so a specific reason to administer an as needed medication should			

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	have been documented on the MAR. Resident #3 Resident #3 was admitted to the facility on 01/06/22, with diagnoses including diabetes, obesity, and anemia. The February 2023 MAR for Resident #3 documented the following: - milk of magnesium 30 milliliters by mouth as needed for constipation and heartburn. On 02/09/23 at 4:00 PM, a Medication Technician confirmed the MAR for Resident #3 did not include a reason to give the as needed medications. On 02/09/23 at 4:10 PM, the Wellness Director verbalized the MAR for Resident #3 should include a reason to give the as needed medication according to what is listed on the physician order. Severity: 2 Scope: 3			

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

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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 record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 15 sampled residents (Resident #9). Findings include: Resident #9 Resident #9 was admitted to the facility on 11/02/21, with diagnoses including dementia and type II diabetes mellitus. Resident #9's record documented a completed ADL assessment dated 10/15/21. Resident #9's record lacked documented evidence an ADL assessment had been completed in 2022. On 02/09/23 at 4:04 PM, the Wellness Director confirmed an ADL assessment had not been completed for Resident #9 in 2022. Severity: 2 Scope: 1	0938	Wellness Director toensure annual ADL assessment is completed for each resident. Executive Directorto monitor though QA.	05/03/2023