STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 02/13/24. 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 Groups beds, assisted living services for elderly or disabled persons and/or persons with Alzheimer's disease, 80 Category II residents and 32 Category II Alzheimer's residents. The census at the time of the survey was 103. Twenty resident files were reviewed and ten employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0074 SS= D	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,	0074	ED to ensure compliance with elder abuse training by directly overseeing new hire checklists to ensure new hires complete training prior to starting work on floor and meeting monthly to schedule renewals with business office manager.	02/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	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 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 personnel file review and interview, the facility failed to ensure 1 of 10 sampled employees received initial elder abuse training prior to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	beginning work at the facility and annually, thereafter (Employee #4). Findings include: On 02/13/24 at 9:28 AM, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 02/13/24, the Business Office Manager provided the completed form with the following information: Employee #4 Employee #4 was hired by the facility as Medcare Manager with a start date of 07/18/23. Employee #4's personnel file contained initial elder abuse training dated 10/25/22; however the personnel file lacked documented evidence of elder abuse training completed in 2023. On 02/13/24 at 12:37 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
0255 SS= F	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 2/13/24, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. The high temperature dishmachine final rinse cycle water temperature was within range at time of inspection, however the wash temperature was below the manufacturer's recommendations. The wash temperature was observed at 130 degrees F. b. The high temperature dishmachine was missing a water softener tank and the valve attachments were laying on the dishroom area floor under the dishmachine. c. The interior surfaces of the kitchen ice machine had mold-like build-up. d. The floors throughout the kitchen and dishwashing area, including the wall surfaces, were heavily soiled with grease and food debris. Soiled floors were noted under the dishwashing machine, three compartment sink, cook's line, and under mounted kitchen equipment. e. The following non-food contact surfaces were soiled: backside of the cook's line, grease fryer, and the backside of the walk-in refrigerator condenser and fan covers. f. The following observations in the Memory Care serving kitchens were repeat deficiencies from previous inspections. Multiple damaged tiles were observed. The counter-top to wall junctures were not sealed to prevent counter-top moisture from penetrating the back wall. The serving kitchen cabinets were not sealed and flush with flooring. The floors throughout the Memory Care 'A' kitchen were soiled with food and debris, including the area under the steam table. Severity: 2 Scope: 3	0255	ED to implement new QA process change for cleanliness of kitchens including monthly deep clean by culinary team after hiring outside service to reset kitchen to baseline cleanliness. Executive Chef and Reflections coordinator to walk reflections kitchens daily and ED to walk memory care kitchens weekly. Community hired vendors to address dish machine, tile and countertop issues cited. Water softener to be replaced with newer model.	03/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
0450 SS= E	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure first aid and cardiopulmonary resuscitation (CPR) training was received within 30 days of employment for 2 of 8 sampled employees working in the facility greater than 30 days (Employee #6 and #8). Findings include: On 02/13/24 at 9:28 AM, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 02/13/24, the Business Office Manager provided the completed form with the following information: Employee #6 Employee #6 was hired by the facility as Care Manager with a start date of 10/4/23. Employee #6's personnel file contained a first aid and CPR certificate dated 11/11/23, greater than 30 days from start date. Employee #8 Employee #8 was hired by the facility as Care Manager with a start date of 09/19/23. Employee #8's personnel file lacked documented evidence of first aid and CPR certification. On 02/13/24 at 12:37 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2	0450	ED to ensure compliance with cpr/first aid training by directly overseeing new hire checklists to ensure new hires complete training prior to starting work on floor and meeting monthly to schedule renewals with business office manager.	02/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
0615 SS= F	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 1. Each residential facility shall have a written policy on admissions which includes: (a) A statement of nondiscrimination regarding admission to the facility and treatment after admission; and (b) The requirements for eligibility as a resident of that type of facility. Inspector Comments: Based on observation and interview, the facility lacked a statement of nondiscrimination regarding admission to the facility and treatment after admission, and the complaint contact information for the Bureau of Health Care Quality and Compliance (Bureau) to report any issues of discrimination. Findings include: On 02/14/24, review of 20 of 20 sampled residents lacked documented evidence of a statement of nondiscrimination with the Bureau's contact information. On 02/14/24 at 10:36 AM, the Administrator confirmed the facility was not informing the resident upon admission with a nondiscrimination statement with Bureau's complaint contact information. Severity: 2 Scope: 3	0615	ED to include notice of non-discrimination with DPBH's contact information in residency agreement that will need to be signed by both resident or their POA and by ED or designee of ED.	03/01/2024
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 and interview, the facility failed to ensure an initial and/or annual general physical examination was completed timely for 3 of 20 sampled residents (Resident #10, #18, and #20). Findings include: Resident #10 Resident	0859	ED to ensure compliance by meeting with Wellness Director monthly to go over residents coming up for annual physical examination. WD to collect visit notes and ED to monitor through monthly QA.	02/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	#10 was admitted to the facility on 04/26/23, with a diagnosis including dementia, hyperlipidemia, and depression. Resident #10's clinical record lacked documented evidence of a general physical examination with a review of systems on or prior to admission. On 02/13/24 at 1:37 PM, the Wellness Director confirmed Resident #10 lacked evidence of a general physical examination for 2023. The Wellness Director confirmed general physical examinations are to be done on or prior to admission, and completed annually there after. Resident #18 Resident #18 was admitted to the facility on 03/29/22, with a diagnosis including heart failure, unspecified, muscle weakness, and age-related physical debility. Resident #18's clinical record documented a physical examination dated 07/15/22. Resident #18's clinical record lacked documented evidence of an annual physical exam for 2023. Resident #20 Resident #20 was admitted to the facility on 11/15/22 with diagnoses including Alzheimer's dementia without behavioral disturbances, history of stroke and osteoarthritis. Resident #20's clinical record documented an admission general physical examination dated 11/02/11. Resident #4's clinical record documented an annual general physical exam dated 12/15/23, 43 days late. On 02/13/24 at 1:37 PM, the Wellness Director confirmed Resident #18 lacked evidence of a physical exam for 2023 and Resident #20's physical exam was late. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
0874 SS= A	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on clinical record review, document review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, was reviewed and initialed by the Administrator within 72 hours for 1 of 20 sampled residents residing in the facility for longer than six months (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility on 02/09/23, with diagnoses including vascular dementia without behavioral disturbance and anxiety. Resident #16's clinical record documented a six-month medication profile review dated 07/13/23. The medication profile review lacked the Administrator's initials. On 02/13/24 at 1:10 PM, the Wellness Director confirmed Resident #16's medication profile review lacked the initials of the Administrator. Severity: 1 Scope: 1	0874	ED to ensure compliance with routine checks to ensure review forms are maintained in charts as 6 month reviews from pharmacist are scheduled and completed.	02/16/2024
0878 SS= F	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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	0878	Wellness Director to obtain orders for TB testing for residents on a yearly basis by end of anniversary month of resident. WD and ED to ensure compliance with change orders with weekly medication cart audits with support from wellness nurse.	02/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	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 record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to ensure 1) medications had a change label and a medication was available on-site for 4 of 20 sampled residents (Residents #14, #12, #13, and #4), and 2) the tuberculosis (TB) testing for residents was administered per physician order potentially affecting 103 of 103 residents in the facility. Findings			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	include: Resident #14 Resident #14 was admitted to the facility on 12/30/23, with diagnoses including pulmonary hypertension, atrial fibrillation, and vitamin D deficiency. During a medication review on 02/13/24, Resident #14 had a bottle of metoprolol with the following documented on the label: - metoprolol succinate extended release 100 milligram (mg) tablets, take one tablet by mouth twice daily. The February 2024 Medication Administration Record (MAR) for Resident #14 and the physician order dated 12/29/23, documented the following: - metoprolol succinate extended release 100 mg tablets, take one tablet by mouth daily. On 02/13/24 at 11:18 AM, the Med Care Manager (MCM) confirmed the medication should have had an order change sticker affixed to the label and the label did not have a change sticker. Resident #12 Resident #12 was admitted to the facility on 11/24/23, with diagnoses including moderate vascular dementia and dyslipidemia. During a medication review on 02/13/24, Resident #12 had a bottle of acetaminophen with the following documented on the label: - acetaminophen 500 mg tablet, take two tablets every six hours as needed. The February 2024 MAR for Resident #12 and the physician order dated 12/13/23, documented the following: - acetaminophen 500 mg, take one tablet by mouth every six hours as needed for mild pain. On 02/13/24 at 11:21 AM, the MCM confirmed the medication should have had an order change sticker affixed to the label and the label did not have a change sticker. Resident #13 Resident #13 was admitted to the facility on 01/23/24, with a diagnosis of pancreatic cancer. During a medication review on 02/13/24, Resident #13 had a medication card of tramadol and a bottle of lorazepam with the following documented on the labels: - tramadol hydrochloride 50 mg tablets, take one tablet by mouth every six hours as needed. - lorazepam intensol 2 mg/milliliter (ml), take 0.25 ml by mouth every two hours as needed for anxiety/dyspnea. The February 2024 MAR and physician orders for Resident #13 documented the following: - tramadol hydrochloride 50 mg tablet, take one tablet by mouth every eight hours. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	corresponding physician order was dated 01/29/24. - lorazepam intensol 2 mg/ml, take 0.25 ml by mouth every two hours as needed for anxiety/agitation. The corresponding physician order was dated 01/24/24. On 02/13/24 at 11:23 AM, the MCM confirmed the medications should have had an order change sticker affixed to the labels and the labels did not have a change sticker. The February 2024 MAR for Resident #13 and a physician order dated 02/05/24, documented the following: - polyethylene glycol 3350 powder, mix 17 mgs into 8 ounces of fluid and give by mouth twice daily for bowel function. The MAR indicated the medication would have been due for the first administration on 02/05/24 at 8:00 PM. The medication was documented as not given at each scheduled administration due to the medication having not been delivered. The polyethylene glycol was not available on site to review. On 02/13/24 at 11:26 AM, the MCM verbalized the medication had been ordered by a hospice agency and was never delivered. The MCM confirmed the medication was ordered on 02/05/24 and had not yet been administered. Resident #4 Resident #4 was admitted to the facility on 09/30/16, with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease. During a medication review on 02/13/24, Resident #4 had the following documented on the medication container labels: -metolazone 5 mg, take one tablet by mouth daily. -haloperidol 0.5 mg, take one half (1/2) tablet by mouth every six hours as needed for nausea. -docusate sodium 100 mg, take one capsule by mouth daily for bowel care. -ventolin hydrofluoroalkane (HFA) 90 micrograms (mcg) inhale one puff by mouth every four hours as needed for shortness of breath. The February 2024 MAR for Resident #4 and the physician orders dated 12/09/23, documented the following: -metolazone 5 mg tablet, take one tablet by mouth every other day for edema. -haloperidol 0.5 mg tablet, take one tablet by mouth every six hours as needed for nausea/vomiting and agitation. -docusate sodium 100 mg softgel, take one capsule by mouth five times a day			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	for constipation. -ventolin HFA 90 mcg, inhale three puffs by mouth every four hours as needed for shortness of breath. On 02/13/24 at 12:51 PM, the MCM confirmed the medications should have had an order change sticker affixed to the container labels and the labels did not have a change sticker. On 02/13/24, a review of 20 sampled residents' clinical records documented TB administration by the Wellness Director, a Registered Nurse and an employee of the facility. On 02/13/24 at 12:13 PM, the Wellness Director (WD) confirmed administering TB tests with tuberculin purified protein (TPP) to residents residing in the facility and confirmed the WD did not have a physician's order to administer the TPP and was not acting in the scope of her practice as a Registered Nurse. Severity: 2 Scope: 3			
1100 SS= F	Weights - Training/Consent - NAC 449.1985 (4) 4. A caregiver may weigh a resident of a residential facility only if: (a) The caregiver has received training on the manner in which to weigh a person that meets the requirements of subsections 5 and 6; and (b) The resident has consented to being weighed by the caregiver. Inspector Comments: Based on record review, document review and interview, the facility failed to obtain the resident or resident's power of attorney consent to take resident's weight measurement for 20 of 20 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, and #20). Findings include: The following residents lacked documented evidence of a signed consent by the resident or the resident's power of attorney to take the resident's weight measurement: - Resident #1 was admitted to the facility on 07/04/23, with diagnoses including age related physical debility and dementia, mild, without disturbance. - Resident #2 was admitted to the facility on 12/28/23, with diagnoses including chronic hypertension, benign prostatic hypertrophy, and chronic left foot pain. - Resident #3 was admitted to the facility on 12/31/22, with diagnoses including chronic heart failure, hypertension, and aortic valve stenosis. -	1100	ED to develop and implement consent form for monthly weight tracking. Resident to be removed from weight tracking if they decline initially or if they change their mind in future and rescind consent for weight tracking/collecting.	04/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	Resident #4 was admitted to the facility on 07/25/23, with diagnoses including atrial fibrillation, hypertension, chronic kidney disease, transient ischemic attack, and congestive heart failure. - Resident #5 was admitted to the facility on 04/27/17, with diagnoses including anxiety disorder, essential hypertension, cerebral infarction, and disorder of lipoprotein metabolism. - Resident #6 was admitted to the facility on 06/22/21, with a diagnosis including Alzheimer's, diverticulosis, and gastroesophageal reflux disease. - Resident #7 was admitted to the facility on 05/23/23, with a diagnosis including dementia, and chronic obstructive pulmonary disease. - Resident #8 was admitted to the facility on 06/23/23, with a diagnosis including restless leg syndrome, and Parkinson's disease. - Resident #9 was admitted to the facility on 12/23/23, with a diagnosis including Parkinson's disease, high blood pressure, and anxiety. - Resident #10 was admitted to the facility on 04/26/23, with a diagnosis including dementia, hyperlipidemia, and depression. - Resident #11 was admitted to the facility on 02/10/22, with diagnoses including vascular dementia and peripheral vascular disease. - Resident #12 was admitted to the facility on 11/24/23, with diagnoses including moderate vascular dementia and dyslipidemia. - Resident #13 was admitted to the facility on 01/23/24, with a diagnosis of pancreatic cancer. - Resident #14 was admitted to the facility on 12/30/23, with diagnoses including pulmonary hypertension and atrial fibrillation. - Resident #15 was admitted to the facility on 03/08/23, with diagnoses including dementia and essential (primary) hypertension. - Resident #16 was admitted to the facility on 02/09/23 with diagnoses including vascular dementia without behavioral disturbances and anxiety. - Resident #17 was admitted to the facility on 12/06/23 with diagnoses including orthostatic hypotension, chronic heart failure and intraparenchymal brain hemorrhage. - Resident #18 was admitted to the facility on 03/29/22 with diagnoses including heart failure, unspecified, muscle weakness and age-related physical debility. - Resident #19 was admitted to the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	on 02/18/22 with diagnoses including dementia without behavioral disturbances, insomnia and essential hypertension. - Resident #20 was admitted to the facility on 11/15/22 with diagnoses including dementia without behavioral disturbances, history of stroke and osteoarthritis. On 02/13/24 at 12:13 PM, the Wellness Director verbalized the Mediation Care Managers measure the resident's weight once a month. The Wellness Director confirmed the facility lacked a physician's order to take resident weights, the results were not reported to the resident's physician and the facility staff lacked the required training and competency evaluation for performing the task affecting 10 of 10 Medication Care Managers. Severity: 2 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 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	1700	ED to monitor through monthly QA reviewing new resident charts to ensure initial physician determination is in place and Wellness Director and ED to monitor current residents through monthly QA to ensure annual physician determinations are in place.	02/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	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 a completed Physician Placement Determination Statement for 2 of 20 sampled residents (Resident #19, and #20). Findings include: Resident #19 Resident #19 was admitted to the facility on 02/18/22, with diagnoses including dementia without behavioral disturbances, insomnia, essential hypertension and age-related physical debility. Resident #19's clinical record lacked a Physician Placement Determination Statement. Resident #20 Resident #20 was admitted to the facility on 11/15/22 with diagnoses including Alzheimer's dementia without behavioral disturbances, history of stroke and osteoarthritis. Resident #20's clinical record lacked a Physician Placement Determination Statement. On 02/13/24 at 1:37 PM, the Wellness Director confirmed Resident #19 and #20 lacked a Physician Placement Determination Statement. Severity: 2 Scope: 1			
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	1830	ED and Wellness Director to complete required infection control training to ensure compliance.	04/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	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 infection control staff lacked the required infection control training. On 02/13/24 at 9:28 AM, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 02/13/24, the Business Office Manager provided the completed form with the following information: Findings include: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 09/20/21. Employee #1's personnel file lacked the required infection control and prevention training required for the primary infection control staff. Employee #2 Employee #2 was hired by the facility as Wellness Director with a start date of 12/27/21. Employee #2's personnel file lacked the required infection control and prevention training required for the primary infection control staff's designee. On 02/13/24 at 12:37 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	Form self-attestation. Severity: 2 Scope: 3			
0895 SS= A	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 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 document review, record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate and Med Care Managers (MCM) documented medication administration correctly on the MAR for 1 of 20 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/04/23, with diagnoses including age related physical debility and dementia, mild, without disturbance. Resident #1's September 2023 MAR documented ibuprofen 800 milligrams (mg). Take one tablet by mouth every six hours with food. The MAR lacked documented evidence the medication was initialed as given or refused on the following dates and times: -09/03/23, 12:00 PM and 12:00 AM -09/04/23, 12:00 PM and 12:00 AM -09/05/23, 12:00 PM,	0895	ED and Wellness Director to ensure physician orders are in place prior to receiving medication. ED to monitor through QA.	02/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
	6:00 PM, and 12:00 AM -09/06/23, 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM -09/07/23, 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM -09/08/23, 12:00 PM and 12:00 AM -09/09/23, 6:00 AM, 12:00 PM, and 12:00 AM -09/10/23, 12:00 PM and 12:00 AM -09/11/23, 6:00 AM, 12:00 PM, and 12:00 AM -09/12/23, 6:00 AM, 12:00 PM, and 12:00 AM -09/13/23 through 09/30/23 were completely blank of administration for all four administration times. Resident #1's MAR did not indicate a discontinuation date and the resident's records did not contain the physician order for ibuprofen. The facility was unable to provide a physician order for ibuprofen for Resident #1. On 02/13/24 at 1:42 PM, the MCM explained if a medication was not administered, the MCM would initial the date and time and circle the initials on the front of the MAR, and document the reason the medication was not given on the back of the MAR. The MCM confirmed Resident #1's MAR was missing administration dates and times and were not initialed, not circled, and the back of the MAR was blank. On 02/13/24 at 1:47 PM, the MCM confirmed Resident #1's chart did not contain a physician's order to administer or discontinue ibuprofen. The MCM explained the MCM was not sure how the medication got onto the MAR without an order. On 02/13/24 at 1:52 PM, the Administrator confirmed Resident #1's chart did not contain a physician order for ibuprofen. Severity: 1 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
1010 SS= D	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on record review and interview, the facility failed to obtain the required endorsement prior to admitting a resident with a diagnosis of mental illness for 1 of 20 sampled residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 02/10/22, with a diagnosis of major depressive disorder, recurrent, unspecified. The facility license lacked an endorsement for the care of a resident with mental illness. On 02/13/24 at 12:33 PM, the Executive Director confirmed the facility lacked an endorsement to care for a resident with a mental illness. Severity: 2 Scope: 1	1010	ED to assist resident/POA in locating and transitioning to community that has mental health endorsement.	05/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/13/2024

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

(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
1050 SS= F	Vital Signs-Glucose - Training/Competency - NAC 449.1985 (1)(a) 1. A caregiver of a residential facility may perform a task described in NRS 449.0304 if the caregiver: (a) Before performing the task, annually thereafter and when any device used for performing the task is changed: (1) Has received training concerning the task that meets the requirements of subsections 5 and 6; and (2) Has demonstrated an understanding of the manner in which the task must be performed; Inspector Comments: Based on observation, record review and interview, the facility failed to ensure 3 of 3 sampled Medication Care Managers were trained in the use of blood pressure monitors and oximetry (Employees #3, #4, and #11). Findings include: On 02/13/24, during the 20 sampled resident clinical record review, residents' clinical records documented monthly vitals were taken at the facility. The following employees lacked documented evidence of training and competency evaluation to take resident vitals: Employee #3 was hired as a Medication Care Manager with a hire date of 08/29/23. Employee #4 was hired as a Medication Care Manager with a hire date of 07/18/23. Employee #11 was hired as a Medication Care Manager with a hire date of 12/14/22. On 02/13/24 at 12:13 PM, the Wellness Director verbalized all Medication Care Managers take resident vitals, including blood pressure, respirations and oxygen saturation, on a monthly basis. The Wellness Director confirmed the facility lacked a physician's order to take resident vitals, the results were not reported to the resident's physician and the facility staff lacked the required training and competency evaluation for performing the task affecting 10 of 10 Medication Care Managers. Severity: 2 Scope: 3	1050	ED to develop training curriculum with support from corporate office for training on taking vital signs including blood pressure, pulse, respirations, pulse oximetry, and weight. ED and business office manager to ensure compliance through QA.	04/30/2024