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 _____	**09/23/2024**

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 a grading resurvey State Licensure survey initiated in your facility on 09/03/2024 and completed on 09/23/204, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 112 Residential Facility for Group beds with 80 beds which provide assisted living services for elderly or disabled persons, Category II residents and 32 beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 86. Twelve resident files and eight employee files were reviewed. The facility received a grade of C. 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. There was one complaint investigated Complaint #NV00072150 with the allegation a resident's medication was not refilled by the facility resulting in the resident suffering severe symptoms requiring hospitalization was substantiated (see tag Y878). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: SAL GOMEZ-OROZCO	Title: Executive Director	Date: 12/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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, 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	0074	Executive Director and Business Office Manager to review onboarding checklists prior to team members first day on floor to ensure initial elder abuse training is complete along with monthly review for current employees to ensure annual renewals are completed on time.	10/14/2024

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	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 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			

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	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 document review, personnel file review, and interview, the Administrator failed to ensure 2 of 9 sampled employees received initial elder abuse training prior to beginning work at the facility or received annual elder abuse prevention training (Employee #3 and #6). Findings include: The facility's Plan of Correction (POC) dated 04/16/2024, documented the Executive Director would ensure compliance with elder abuse training by directly overseeing new hire checklists to ensure new hires complete training prior to starting work on the floor and meeting monthly to schedule renewals with Business Office Manager. The POC documented the correction date as 02/14/2024. On 09/03/2024 at 8:32 AM, the Executive Director was provided with the Personnel Check List to complete for nine sampled employees. On 09/03/2024 at 9:36 AM, the Business Office Manager provided the completed form with the following information: Employee #3 Employee #3 was hired by the facility as the Reflections Memory Care Coordinator with a start date of 08/12/2019. Employee #3's personnel file documented an annual elder abuse prevention training on 03/13/2023. Employee #3's personnel file lacked documented evidence of elder abuse prevention training for 2024. Employee #6 Employee #6 was hired by the facility as a			

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	Care Manager with a start date of 04/19/2024. Employee #6's personnel file documented elder abuse prevention training dated 05/02/2024, 13 days after working with residents. On 09/03/2024 at 12:49 PM, the Business Office Manager confirmed Employee #3 lacked annual elder abuse prevention training and Employee #6 lacked timely initial elder abuse prevention training prior to working in the facility. The facility policy titled "Abuse Prevention, Investigation and Reporting Policy and Procedure," revised 07/2021, documented all team members, regardless of discipline, will be trained on abuse and neglect upon hire and, at a minimum, annually thereafter. This is a repeat deficiency from the Annual State Survey dated 02/13/2024. Severity: 2 Scope: 1			
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.	0255	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 7NG211.	09/03/2024
0450 SS= D	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 record review, document review, and interview, the facility failed to ensure employees obtained timely cardiopulmonary resuscitation (CPR) and first aid training for 1 of 9 sampled employees working at the	0450	Executive Director and Business Office Manager toreview cpr/first aid certificates on incoming employees to ensure they are approvedby American Red Cross and will ensure all team members undergo approved trainingwithin first 30 days of employment. A review was done of existing employees toidentify any other team members who may have had certificates that didn’t meetRed Cross standard and have been sent for retraining by Red Cross approvedprogram. Team member referenced is no longer employed at this facility.	10/21/2024

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	facility greater than 30 days (Employee #4). Findings include: The facility's Plan of Correction (POC) dated 04/16/2024, documented the Executive Director would 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. The POC documented the correction date as 02/14/2024. On 09/03/2024 at 8:32 AM, the Executive Director was provided with the Personnel Check List to complete for 9 sampled employees. On 09/03/2024 at 9:36 AM, the Business Office Manager provided the completed form with the following information: Employee #4 Employee #4 was hired by the facility as a Med Care Manager with a start date of 01/18/2024. Employee #4's personnel file contained documented evidence of CPR and first aid training dated 11/02/2023. The CPR and first aid vendor did not meet the required comparable training requirements, including skills testing, as the American Red Cross per regulation. The CPR and first aid training was invalid. On 09/03/2024 at 10:56 AM, the Business Office Manager confirmed Employee #4's CPR and first aid training was not compliant with the regulation since the training did not include skills testing and was not one of the nationally recognized organizations per the facility's policy. The facility policy titled "Cardiopulmonary Resuscitation (CPR) Response Policy and Procedure," revised 07/2021, documented the facility would accept CPR and first aid training from the following nationally recognized organizations, including, American Red Cross, American Heart Association, National Safety Council and American Safety and Health Institute. This is a repeat deficiency from the Annual State Survey on 02/13/2024. Severity: 2 Scope: 1			

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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.	0615	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 7NG211.	09/03/2024
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.	0859	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 7NG211.	09/03/2024
0874 SS= D	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 document review, record 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	0874	Executive Director to maintain binder withpharmacist reviews in office including list of residents identified as “norecommendations made” by pharmacist along with keeping individual review formsin resident charts. Executive Director has communicated with reviewing pharmacyto have signature lines and date lines for ED to be included on all reviewforms including any bulk lists.	10/14/2024

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	within 72 hours for 2 of 12 residents residing in the facility for longer than six months (Resident #3 and #4). Findings include: The Plan of Correcton (POC) submitted 04/16/2024, documented the Executive Director would ensure compliance with routine checks to ensure review forms are maintained in charts as 6 month reviews from the pharmacist are scheduled and completed. The POC documented the correction date as 02/16/2024. Resident #3 Resident #3 was admitted to the facility on 02/15/2024, with diagnoses including hypertension and chronic respiratory failure. Resident #3's medication profile review dated 07/09/2024, lacked the date of the Administrator's review and could not be verified as reviewed within the required 72 hours. Resident #4 Resident #4 was admitted to the facility on 04/17/2024, with diagnoses including Parkinson's disease, and arthritis. Resident #4's medication profile review dated 07/09/2024, lacked the date of the Administrator's review and could not be verified as reviewed within the required 72 hours. On 09/03/2024 at 11:15 AM, the Wellness Director verbalized the medication reviews for Resident #3 and Resident #4 lacked the date of the Administrators review. This is a repeat deficiency from the Annual State Survey dated 02/13/2024. Severity: 2 Scope: 1			
0878 SS= G	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	Executive Director and Wellness Director toensure medications are available and on site. ED and WD also to ensure anymedications that are kept in resident’s apartment are clearly marked on MAR asbeing stored as such. In response to complaint survey, Executive Directorworked with pharmacy and eMAR company to implement new safeguards includingautomated emails to Executive Director and Wellness Director whenever anymedication is d/c’d as	10/02/2024

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	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, record review, and document review, the facility failed to ensure a medication was onsite to administer the prescribed dosage and a		heart of issue isn't that medications weren't ordered,it was that the medication was entered as having a d/c date by pharmacy.Product changes also made to eMAR platform to include medications that have anupcoming d/c date as that was previously unavailable to community. Executive Directorand Wellness Director along with the rest of Wellness leadership to reviewrecently d/c'd meds at daily meeting to further keep tabs on d/c'd and soon tobe d/c'd medications.	

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	medication was refilled and administered as prescribed for 2 of 13 sampled residents (Resident #1 and #13). Resident #1 Resident #1 was admitted to the facility on 06/24/2024, with diagnoses including hypertension with heart failure, atrial fibrillation, and acute systolic heart failure. Resident #1's September Medication Administration Record (MAR) documented Remedy Calazime Protect Paste. Apply one application topically twice daily as needed for skin breakdown/ulceration. Resident #1's Remedy Calazime Protect Paste was not found in the medication cart during the medication review. On 09/03/2024 at 12:48 PM, the Medication Technician (MT) verbalized the paste was not located in the medication cart. The MT explained the medication had not been requested by the resident and had not been administered. A physicians order dated 07/15/2024, documented Remedy Calazime Protect Paste. Apply one application topically twice daily as needed for skin breakdown/ulceration. On 09/03/2024 at 12:50 PM, the Wellness Director verbalized the medication should be onsite to administer when the resident requested. Resident #13 Resident #13 was admitted to the facility on 09/12/2023, with a diagnosis of hypothyroidism. A medication order for Resident #13, dated 03/06/2024, documented levothyroxine (a synthetic version of a hormone created in the thyroid gland used to prevent the symptoms of hypothyroidism) 88 micrograms (mcg) tablet, take one tablet by mouth daily for 90 days with three refills. The June 2024 MAR for Resident #13 documented the levothyroxine was discontinued on 06/05/2024. The medication was not documented on the MARs for July or August of 2024. A Physician Notification form, dated 08/20/2024, documented Resident #13 had been stating it was getting harder to walk from the resident's room to the dining hall and from outside to inside. The resident would have to stop and			

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	take a break halfway through the walk. The resident had also been forgetting the time of day. A Physician Notification form, dated 08/28/2024, documented Resident #13 was observed to be coughing and congested. The resident's face was swollen, and the whites of the resident's eyes were yellow. The resident complained of shortness of breath. A Physician Notification form, dated 09/01/2024, documented Resident #13's family was informed of the resident having swollen feet and the family took the resident to the hospital for evaluation on 08/31/2024. An After Visit Summary from the resident's hospitalization on 08/31/2024 through 09/06/2024, documented the resident's primary diagnosis had been myxedema coma (severe hypothyroidism). On 09/23/2024 at 10:20 AM, a pharmacist with the facility's contracted pharmacy verbalized the pharmacist would have refilled the order based on the prescription documenting the medication had three refills. On 09/23/2024 at 10:27 AM, the Wellness Director (WD) confirmed the levothyroxine for Resident #13 had been stopped suddenly when the initial 90-day supply ran out on 06/04/2024. The WD explained the procedure for refilling medication was for the staff to click on a refill button for the medication or most medications were refilled monthly on what was called a "cycle fill." The WD verbalized the medication looked like it had ended since the order was written as a 90-day supply, so the facility did not order a refill. The WD confirmed there was not a process for ensuring a physician order/prescription had been entered appropriately in the MAR to ensure refills were ordered timely. On 09/23/2024 at 10:39 AM, a representative for Resident #13 communicated the resident's family had inquired on 08/31/2024 as to why the resident's medication list did not include the resident's thyroid medication and were told by a Caregiver the medication had been discontinued. The representative communicated the wellness			

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	staff had not informed the resident's family the medication had been discontinued. On 09/23/2024 at 11:08 AM, the Administrator verbalized the medication was not continued for Resident #13 because of the way the Physician had written the order, and the missed medications were not flagged as a medication error by the facility. The Administrator verbalized the facility had not provided any training to staff regarding medication refills or made any changes to the medication refill process. The facility policy titled "Medication Errors Policy and Procedure," dated 07/2021, documented a medication error was an incident involving medicines where there was an error in the process of prescribing, dispensing, or administering. Examples included when any prescribed dose was not given and medication omitted without a clinical rationale. Complaint #NV00072150 Severity: 3 Scope: 1			

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

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		A. BUILDING _____ B. WING _____	**09/23/2024**

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, clinical record review, interview and document review, the facility failed to ensure a discontinued medication was destroyed for 1 of 12 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 06/24/2024, with diagnoses including hypertension with heart failure, atrial fibrillation, and acute systolic heart failure. Resident #1's medications contained a a bottle of ergocalciferal 50000 (Vitamin D2) unit capsule, take one capsule by mouth every seven days. Resident #1's September Medication Administration Record lacked an entry for Vitamin D2 50000 unit capsule. A Physician's Order dated 08/02/2024, documented Vitamin D2 50000 unit capsule, take one capsule by mouth every seven days for 360 days. On 09/03/2024 at 12:36 PM, a Medication Technician verbalized the medication had been discontinued and should have been removed from Resident #1's medications and destroyed. An admission order dated 08/19/2024, documented to discontinue Vitamin D2. On 09/03/2024 at 12:41 PM, the Wellness Director verbalized the expectation was to remove and destroy medications when a discontinue order was received. Severity: 2 Scope:1	0885	Wellness Director andWellness leadership to ensure d/c'd medications are removed from med cart anddestroyed per company policy whenever a d/c order is received. ExecutiveDirector to monitor through cart audits.	10/07/2024

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0905 SS= D	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 written instructions indicating the specific symptom (s) for which an as needed (PRN) medication was to be administered to a resident was documented for 1 of 12 sampled residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 02/22/2024, with diagnoses including dementia, and hypertension. Resident #11's September 2024 Medication Administration Record (MAR) documented Acetaminophen 500 milligrams (mg) capsule. Take two tablets by mouth every six hours as needed. The MAR lacked the symptom for which the medication was ordered to treat. Resident #11's physician orders dated 02/08/2024, documented Acetaminophen 500mg capsule. Take two tablets by mouth every six hours as needed. The physician orders lacked the symptom for which the medication was ordered to treat. On 09/03/2024 at 12:52 PM, the Medication Technician verbalized Resident #11's September 2024 MAR and physician order	0905	Wellness Director and Wellness leadership to review medications as they are received to ensure all PRN orders have a listed diagnosis included along with instructions. Executive Director to monitor through eMAR audits. Resident mentioned in tag is no longer in community as they moved out of state.	10/02/2024

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	lacked the symptom for which the medication was ordered to treat and should have obtained a clarification order to specify the symptom. Severity: 2 Scope: 1			
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.	1010	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 7NG211.	09/03/2024
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 personnel file review, document review, and interview, the facility failed to provide training and competency assessment for 7 of 7 employees measuring resident vitals (Employee #2, #3, #4, #5, #6, #7, and #8). Findings include: The facility's Plan of Correction (POC) dated 04/16/2024, documented the Executive Director (ED) would develop training curriculum with support from corporate office for training on taking vital signs including blood pressure, pulse, respirations, pulse oximetry, and weight. The ED and Business Office	1050	Executive Director and Wellness Director to ensure team members receive proper training from external trainer and that training is done along with skills checklist by external trainer. Per conversation during with lead surveyor, Executive Director to also obtain training from external trainer in a "train the trainer" manner so that Wellness leadership can provide needed training for team members. External trainers to fill out paperwork attesting to both direct training provided to team members and to ability of Wellness leadership to train employees. Executive Director and Business Office Manager to monitor yearly renewal of vitals and weight training to ensure renewals done on time.	12/13/2024

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	Manager would ensure compliance through Quality Assurance. The POC documented the correction date as 04/30/2024. On 09/03/2024 at 8:32 AM, the Executive Director was provided with the Personnel Check List to complete for 9 sampled employees. On 09/03/2024 at 9:36 AM, the Business Office Manager provided the completed form with the following information: The facility's education and in-service record dated 07/30/2024, documented a program title of weights, vitals and catheter change. The document lacked evidence of a trainer's name and credentials, weight training in the curriculum, evidence of what equipment was used for the training, and competency skills testing for pulse rate, respiration rate and blood pressure. The following employees performing vitals signs on residents in the facility lacked documented training with competency evaluation: - Employee #2 was hired by the facility as the Wellness Director with a start date of 09/20/2021. - Employee #3 was hired by the facility as the Reflections Memory Care Coordinator with a start date of 08/12/2019. - Employee #4 was hired by the facility as a Med Care Manager with a start date of 01/18/2024. - Employee #5 was hired by the facility as a Med Care Manager with a start date of 03/14/2024. - Employee #6 was hired by the facility as a Care Manager with a start date of 04/19/2024. - Employee #7 was hired by the facility as a Care Manager with a start date of 07/16/2024. - Employee #8 was hired by the facility as a Care manager with a start date of 08/26/2024. On 09/03/2024 at 11:17 AM, the Business Office Manager confirmed the vitals training lacked evidence of a trainer's name and credentials, weight training in the curriculum, evidence of what equipment was used for the training, and competency skills testing for pulse rate, respiration rate and blood pressure. This is a repeat deficiency from the Annual State Survey of 02/13/2024. Severity: 2 Scope: 3			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 9 of 12 sampled residents (Resident #1, #2, #3, #4, #5, #6, #10, #11, and #12). Findings include: The Plan of Correction (POC) submitted 04/16/2024, documented the Executive Director would 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. The POC documented the correction date as 04/30/2024. The POC documented the correction date as 04/30/2024. 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 06/24/2024, with diagnoses including hypertension with heart failure, atrial fibrillation, and acute systolic heart failure. - Resident #2 was admitted to the facility on 02/15/2024, with diagnoses including radiculopathy and congestive heart failure. - Resident #3 was admitted to the facility on 02/15/2024, with diagnoses including hypertension and chronic respiratory failure. - Resident #4 was admitted to the facility on 04/17/2024, with diagnoses including Parkinson's disease, and arthritis. - Resident #5 was admitted to the facility on 08/09/2024, with diagnoses including dementia, memory loss, and diabetes type two. - Resident #6 was admitted to the	1100	Executive Director and Wellness Director toensure team members receive proper training from external trainer and thattraining is done along with skills checklist by external trainer. Perconversation during surveyor, Executive Director to alsoobtain training from external trainer in a "train the trainer" mannerso that Wellness leadership can provide needed training for team members.External trainers to fill out paperwork attesting to both direct trainingprovided to team members and to ability of Wellness leadership to trainemployees. Executive Director and Business Office Manager to monitor yearlyrenewal of vitals and weight training to ensure renewals done on time. Executive Director and Wellness Director to ensure orders for monthly weight recording are obtain for residents who have opted in for weight tracking and have signed an agreement for weight tracking which will include verbiage that residents can withdraw their consent at any time without reason.	12/31/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	facility on 07/25/2024, with diagnoses including congestive heart failure and peripheral vascular disease. - Resident #10 was admitted to the facility on 02/22/2024, with diagnoses including dementia, hypertension, and hypothyroidism. - Resident #11 was admitted to the facility on 02/22/2024, with diagnoses including dementia, and hypertension. - Resident #12 was admitted to the facility on 02/15/2024, with diagnoses including dementia, hypertension, and gait. On 09/03/2024 at 1:03 PM, the Wellness Director verbalized the facility had not fully implemented the consent form for weight tracking/collecting to all resident's within the facility. The facility policy titled "Weights Waiver - Nevada," effective 06/27/2024, documented resident weights may only be taken if resident consents to being weighed. This is a repeat deficiency from the Annual State Survey of 02/13/2024. 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	1700	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 7NG211.	09/03/2024

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	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)			

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1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training.	1830	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 7NG211.	09/03/2024