Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	02/11/2025

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 02/11/2025, 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 97. Twenty resident files were reviewed and fifteen 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. 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		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: PAULA ALLEC Title: Administrator Date: 03/07/2025

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0170 SS= F	Health And Sanitation-Safe Water & Sewage - NAC 449.209 Health and sanitation. (NRS 449.0302) 1. A residential facility must: (a) Have a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage. Inspector Comments: Based on measurement and interview, the facility failed to ensure water temperature was at a safe level. Findings include: On 02/11/2025 at 9:15 AM, water temperature in the memory care unit was measured with a State issued thermometer. The water temperature measured 126 degrees Fahrenheit. On 02/11/2025 at 9:15 AM, the Maintenance Director confirmed the water temperature measurement and verbalized the water temperature should be between 115 degrees Fahrenheit and 120 degrees Fahrenheit. Note: Time and temperature relationship to third degree burn to occur: 155 degrees Fahrenheit 1 second 148 degrees Fahrenheit 2 seconds 140 degrees Fahrenheit 5 seconds 133 degrees Fahrenheit 15 seconds 127 degrees Fahrenheit 1 minute 124 degrees Fahrenheit 3 minute 120 degrees Fahrenheit 5 minutes 100 degrees Fahrenheit Safe for bathing Severity: 2 Scope: 3	0170	Maintenance Director will closely monitor water temperatures in memory care on a weekly basis to ensure that temperatures meet the state regulations of 115 - 120 degrees Fahrenheit to ensure safety of residents and staff. Maintenance Director will notify the Administrator if temperatures are above the previously stated regulated temperatures to determine next actions.	02/12/2025
0250 SS= F	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation and interview, the facility failed to ensure 1) the high temperature dishwasher reached the appropriate temperature to sanitize dishes, 2) the refrigerators were registering between 36 and 41 degrees for 2 of 2 refrigerators in the memory care unit, and 3) hair restraints were worn by staff in the	0250	1)Executive Chef and Maintenance Director ensured repair of the dishwasher to reach proper and state regulated sanitation temperature of 180 degrees for effective sanitation. 2)Executive Chef and Dining room supervisor will monitor temperature logs checked by floor staff, to ensure that all community refrigerators temperatures are between 36 and 41 degrees. Floor staff has also been retrained on food safety and temperature and what steps to take when the refrigerator temperature is out of safe range, by immediately notify maintenance of the issue, remove any food and place the	02/12/2025

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	facility's kitchen. This deficient practice in the kitchen where food was prepared and stored had the potential to affect the entire resident census. Findings include: High Temperature Dishwasher On 02/11/2025 at 8:54 AM, the Food Services Director operated the high temperature dishwasher. The temperature rose to 130 degrees during the high temperature rinse. The dishwasher failed to reach a temperature of 180 degrees, a temperature required to sanitize. On 02/11/2025 at 8:57 AM, the Food Services Director verbalized the temperature was required to reach 180 degrees to effectively sanitize the dishes. The Food Services Director confirmed the temperature needed to reach 180 degrees to effectively sanitize. Refrigerator Temperature On 02/11/2025 at 9:20 AM, during the satellite kitchen tour in the memory care unit, both refrigerators' temperatures were above 41 degrees. The temperature log for refrigerator A documented from 02/01/2025 - 02/11/2025 the refrigerator temperature was above 41 degrees. The current temperature was 44 degrees. The temperature log for refrigerator B lack documented temperatures from 02/06/2025 - 02/09/2025. The current temperature was 42 degrees. On 02/11/2025 at 9:47 AM, the Food Services Director confirmed the temperatures for both refrigerators were accurate, and verbalized being unaware of the issue. The facility policy titled "Temperature Log Policy," undated, documented temperature was one of the critical factors with the food services operation. Refrigerators were used for short-term holding of foods at temperatures of 40 degrees or lower. Record the temperature of each refrigerator on a temperature log once a day. Hairnets/Restraints On 02/11/2025 at 8:54 AM, during a tour of the facility kitchen, staff members were in the kitchen and were not wearing a hair restraint. A server was buttering toast for a resident in the dining room, a kitchen aide was washing dishes and pulling dishes from the dishwasher to be put away. On 02/11/2025 at 9:10 AM, the Food Services Director verbalized the employees did not need to wear a hairnet if		unit out of order until brought to proper temperature. The units were repaired on 2/12/25 3)Executive Chef and Dining room supervisor will follow community policy and state regulation that a team member working in the kitchen as someone preparing food for service in any manner shall wear hair restraints such as hats, hair covers, hair or beard nets or other effective means to effectively keep hair from contacting exposed food, clean equipment, utensil and linens. Servers and care staff members may be asked to assist with preparation of foods; these team members were required to wear a hair restraint during all phases of meal service.	

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	their hair was short or pulled up and servers did not need to wear them. The facility policy titled "Hair Restraints Policy," effective 08/2021, documented a team member working in the kitchen as someone preparing food for service in any manner shall wear hair restraints such as hats, hair covers, hair or beard nets or other effective means to effectively keep hair from contacting exposed food, clean equipment, utensil and linens. Servers and care staff member may be asked often asked to assist with preparation of foods these team members were required to wear a hair restraint during all phases of meal service. Severity: 2 Scope: 3			
0252 SS= D	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation and interview, the facility failed to discard expired food. Findings include: On 02/11/2025 at 8:54 AM, during the kitchen tour, located in the kitchen dry storage was ten, 46-ounce cans of tomato juice with an expiration date of 09/12/2024. On 02/11/2025 at 9:04 AM, the Food Services Director confirmed the expired food items were to be discarded by the expiration date. Severity: 2 Scope: 1	0252	Executive Chef and Dining Room Supervisor will perform weekly checks of the food storage to ensure there is no expired food present in dry storage and walk in refrigerator. If there expired goods are located staff will properly dispose of expired items right away. The Administrator will conduct a monthly inspection to verify all food is stored according to its proper expiration date and ensure that all products are being rotated and stored appropriately to maintain freshness.	02/11/2025

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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 file review and interview, the facility failed to ensure an employee had current first aid and cardiopulmonary resuscitation (CPR) training 1 of 14 sampled employees working in the facility greater than 30 days (Employee #1). Findings include: On 02/11/2025 at 9:25 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 02/13/2025 at approximately 1:00 PM, the Administrator provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 10/1/2022. Employee #1's personnel file contained a first aid and CPR certificate dated 02/16/2022 and a first aid and CPR certificated dated 02/05/2025, greater than the two-year certification period. On 02/11/25 at 2:02 PM, the Administrator provided the Attestation of Compliance form, signed and dated 02/12/2025, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0450	Executive Director to ensure compliance with cpr/firstaid training by directly working with business office to ensure new hires complete training prior to starting work on floor and meeting monthly to schedule renewals with business office manager. Anyone with expired cpr/first aid will be pulled off the floor immediately until training is up to date.	02/11/2025

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0522 SS= D	Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 2. A person-centered service plan developed pursuant to this section must include, without limitation: (k) If the resident has Alzheimer ' s disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility, including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if: Inspector Comments: Based on clinical record review and interview, the facility failed to ensure a person-centered service plan (care plan) contained interventions for a resident with dementia/memory loss for 1 of 20 sampled residents (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility on 08/09/2024, with diagnoses including Alzheimer's/dementia. Resident #16's clinical record contained a care plan initiated on 08/09/2024, however the care plan lacked interventions for the care and treatment of dementia/memory loss. On 02/11/2025 at 1:17 PM, the Wellness Director verbalized the required components of a care plan were focus, goals, and interventions. The Wellness Director explained a care plan was created for a specific purpose and should have interventions listed. The Wellness Director confirmed the care plan for Resident #16 lacked interventions for dementia/memory loss. Scope: 2 Severity: 1	0522	Wellness Director and coordinators will implement the person-centered service plan for each resident, ensuring it is tailored to their individual needs and preferences. They will will take proactive measures to address the specific needs related to dementia care and ensure the safety and well-being of the resident by incorporating appropriate interventions into the Resident's care plan to manage symptoms and ensure safety and will be regularly reviewing and updating the care plan to reflect any changes in the resident’s condition.	02/14/2025
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected.	0920	Wellness director will go through an orientation check list with any new and current resident that are self administering their medications. Every 6 months the check list will be reviewed with the resident, or sooner if random room sweeps indicate noncompliance with polices and regulations. Any resident found to be unable to comply with policy and regulations will be asked to have facility administer medications. Attached is orientation document that will be used.	02/28/2025

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	Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure 1.) medications in a resident room was safely stored in a locked area and inaccessible to other residents or visitors for 2 of 13 resident rooms (Room #107 and #207) and 2.) resident medications were kept secured in the facility for 1 of 20 sampled residents (Resident #18). Findings include: On 02/11/2025, the following resident rooms contained unsecured medications: Room 107 - at 10:54 AM, the two occupying residents were present in the room. The room was occupied by spouses. One spouse was approved to self-administer medications, and the other spouse was not approved to self-administer medications. The following medications were stored unsecured in the resident room: - a container of Losartan - a container of Atorvastatin - a container of Levothyroxine - a container of melatonin - a container of cranberry capsules On 02/11/2025 at 10:54 AM, the self-administering resident verbalized the spouse was left alone in the room for 10 - 15 minutes at a time. Room 207 - at 11:18 AM, the two occupying residents were not present in the room. The room was occupied by spouses. One spouse was approved to self-administer medications, and the other spouse was not approved to self-administer medications. The following medications were stored in a medicine cabinet with the key left in the lock: - a container of One-a-Day Women's vitamins - a container of One-a-Day Men's vitamins - a container of stool softener - a container of Tylenol - a container of vitamin			

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	D On 02/11/2025 at 11:18 AM, the Maintenance Director confirmed the medication in the bathroom cabinet was not secured. Resident #18 Resident #18 was admitted to the facility on 01/31/2025, with diagnoses including hypertension, diabetes and chronic respiratory failure. On 02/11/2025 at 1:10 PM, the following were located in the bathroom of Resident #18's room: -four bottles of gummy multi-vitamins -one bottle of tums -two bottles of blood sugar ultra pills -two bottles of allergy tablets -one bottle of magnesium tablet -one bottle of hydrogen peroxide -one tube of zinc paste On 02/11/2025 at 12:40 PM, the Medication Technician verbalized Resident #18 should not have any medications in the room without a physician's order to self-administer. The Medication Technician confirmed the medications were present. Severity: 2 Scope: 1			

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 20 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility on 08/09/2024, with diagnoses including memory loss, type two diabetes and hypertension. Resident #16's clinical record lacked documented evidence of an initial two-step TB test upon admission to the facility. On 02/11/2025 at 12:37 PM, the Wellness Director confirmed TB testing for Residents #16 had not been completed. Severity: 2 Scope: 1	0936	Wellness Director to ensure all new admissions have completed TB testing prior to being admitted to community, by thoroughly reviewing all documents prior to resident admission to community. Administrator to monitor through QA.	02/12/2025

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents housed in the memory care unit for 17 of 17 residents. Findings include: On 02/11/2025 at 9:45 AM, the door into the memory care kitchen was unlocked and slightly opened and unattended. The kitchen had a hot coffee pot sitting on the counter. The cabinet under the sink contained the following: - Two 21-ounce containers of Ajax - A container of odor eliminator - Two 33.8-ounce containers of hand sanitizer - A 10-ounce container of air freshener On 02/11/2025 at 9:45 AM, the Maintenance Director confirmed the items could potentially harm residents and should be secured. The facility policy titled "Safety Reflections Protocol," revised July 2021, documented, "Kitchen entry/exit doors must be secured" and "Never leave chemicals, cleaning products, or tools unsupervised or unlocked. The facility policy titled "Safety Reflections Protocol," revised July 2021, documented resident suites must be free of chemicals, items labeled "keep out of reach of children," items known to be potentially hazardous, knives, or other sharp instruments and medications. Severity: 2 Scope: 3	0999	Associate Executive Director and Reflections coordinator will ensure that restricted items are kept secured in locked cabinets and drawers for memory care residents, by observing all areas during routine daily walks. Coordinator to ensure all areas, including kitchens and entries/exits, are kept secured for the safety of all residents. Wellness Director/AED to monitor through monthly QA. Staff also retraining on process of keeping restricted items locked in cabinets.	02/21/2025
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or	1600	Administrator found company policy and procedure to assure all residents are treated with respect regarding preferred pronouns, expressed gender identity and preferred names. Staff was trained on the policy and procedure, and all resident records were updated with preferred pronouns. Attached a copies of policies.	02/21/2025

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	resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility failed to develop policies to ensure residents were addressed by the resident's preferred name and pronoun in accordance with the resident's gender identity or expression and failed to include the residents preferred name and pronoun in the resident records. This deficient practice affected the entire facility census. Findings include: On 02/11/2025 at 10:58 AM, the Administrator verbalized the facility had not collected from			

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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
	any resident the resident's preferred name and pronoun in accordance with the resident's gender identity or expression due to the facility's ownership. The Administrator verbalized having been responsible for ensuring compliance with State regulations. On 02/11/2025 at 2:41 PM, the Administrator verbalized the facility had not developed policies ensuring residents were addressed by the resident's preferred name and pronoun in accordance with the resident's gender identity or expression or to ensure the residents preferred name and pronoun were documented in the resident records. Severity: 2 Scope: 3			