

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2023
NAME OF PROVIDER OR SUPPLIER OUR HOME ADULT LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4180 SIERRA MADRE DR, RENO, NEVADA ,89502		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 02/15/22. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for five Residential Facility for Group beds for elderly or disabled persons, Category II residents. The census at the time of the survey was three. Three resident files were reviewed and four employee files were reviewed. The facility received a grade of B. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:			

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 Name: JONATHAN SAPICO Title: director
REPRESENTATIVE'S SIGNATURE

Date: 04/13/2023

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(X4) ID PREFIX TAG 0065 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0065	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 04/13/202 3
	Qualifications of Caregivers-Age-Eng- Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 4 employees obtained the required eight hours of annual caregiver training. (Employee #1, #2, #3, #4). Findings include: Employee #1 Employee #1 was hired as the Administrator with a start date of 03/20/18. The personnel record for Employee #1 lacked documented evidence of annual caregiver training hours in 2022. Employee #2 Employee #2 was hired as the Director with a start date of 03/10/18. The personnel record for Employee #2 lacked documented evidence of annual caregiver training hours in 2022. Employee #3 Employee #3 was hired as caregiver with a start date of 02/28/20. The personnel record for Employee #3 lacked documented evidence of annual caregiver training hours in 2022. Employee #4 Employee # 4 was hired as caregiver with a start date of 10/01/17. The personnel record for Employee #4 lacked documented evidence of annual caregiver training hours in 2022.. On 02/15/23 at 11:46 AM, the Director confirmed there were no annual caregiver trainings of eight credit education unit (CEU) hours located in any of the employee files for the year of 2022. Severity: 2 Scope: 3		The director will be doing monthly checks on employee files to ensure that all required training is met on time. On Feb.15 at the time of the survey the 2022 caregiver training record was not in the facility and the administrator confirmed that she has it in her file. On Feb 16th, 2023, the proof of training for the caregivers are placed in their respective files.	

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(X4) ID PREFIX TAG 0178 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the hallway bathroom sink functioned properly. Findings include: On 02/15/23 at 9:18 AM, in main hallway resident bathroom, the sink was not properly draining. On 02/15/23 at 9:20 AM, the Director confirmed the sink should be draining properly, and he was not aware it was not draining. The Director put an immediate call out to a plumber to fix the clogged sink, and confirmed it would be taken care of as soon as possible. Severity: 2 Scope: 1	ID PREFIX TAG 0178	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Om Feb.15 2023 The sink was fixed and now functioning properly. The director inspected it after the drainpipe was cleared with clogs. The director will do weekly inspections of the facility to ensure everything is working properly.	(X5) COMPLETION DATE 04/13/202 3

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(X4) ID PREFIX TAG 0620 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0620	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 04/13/2023
	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 1 of 3 residents receiving skilled nursing services (Resident #1). Findings include: Resident #1 was admitted to the facility on 07/05/21, with a diagnoses of dementia, stroke, and type 2 diabetes. On 02/09/23 at 4:05 PM, the Director verbalized the facility had a resident receiving 24-hour skilled nursing care through a hospice agency (Infinity Hospice). The Director confirmed they were not aware of the requirement to submit waivers to the State Agency for residents receiving 24-hour skilled nursing care. The Director confirmed the facility had not submitted waivers to the State Agency to retain residents receiving 24-hour skilled nursing care. Severity: 2 Scope: 1		On April 10,2023 the director of the facility submitted the application online for the bedfast waiver for resident 1 who is under hospice care. The applicant was submitted through the DPBH website under BHQC.	

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(X4) ID PREFIX TAG 0870 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0870	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 04/13/2023
	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a resident admitted for six months or greater had a review of medications for accuracy and appropriateness for 1 of 3 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/05/21, with a diagnoses of dementia, stroke, and type 2 diabetes. Resident #1's record lacked documented evidence medication reviews had been completed no later than six months after admission to the facility and subsequently every six months after. On 02/15/23 at 9:50 AM, the Director confirmed Resident #1 lacked evidence of six month medication reviews and verbalized medication reviews were to be completed no later than six months after admission to the facility and every six months thereafter. Severity: 2 Scope: 1		Resident 1 is under hospice care. On April 12 2023 hospice was contacted by the director to request a current med review and plan. Hospice replied on April 13th with the current med review and plan of care. The director will be doing monthly inspections of the residents file to comply with the requirements.	

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(X4) ID PREFIX TAG 0923 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0923	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 04/13/202 3
	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, record review, and document review, the facility failed to ensure a prescribed medication was stored and labeled properly in its original container with the name of the resident, and ordering physician on the medication bottle for 1 of 3 residents (Resident # 3). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/05/21, with a diagnoses of dementia, stroke, and type 2 diabetes. Resident #1's Medication Administration Record (MAR) dated February 2023; documented Lorazepam 2 milligrams (mg) give 0.25 milliliters (ml) by mouth every six hours. The medication was located in Resident #1's medication bin; however, the medication was not stored in its originally labeled container. On 02/15/23 at 11:00 AM, the Caregiver confirmed the Lorazepam container did not have the name of the resident and ordering physician on the medication bottle and verbalized the names needed to be present on the bottle to identify to which resident the medication belonged. Severity: 2 Scope: 1		On FEb.15,2023 the director of the facility showed the caregiver the proper storage and labeling of medications with the emphasis on making sure that the original container and box with the resident's name and physician prescribing the medication are on the medication. The director does a weekly inspection of every resident's medication.	

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(X4) ID PREFIX TAG 1305 SS= C	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 1305	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 04/13/202 3
	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. Inspector Comments: Based on observation and interview, the facility failed to post a current non-discrimination statement prominently in the facility. Findings include: On 02/15/23 at 9:00 AM, the facility lacked a current nondiscrimination statement for residents and the public to view. On 02/15/23 at 9:15 AM, the Administrator acknowledged a nondiscrimination statement was not posted prominently in the facility and was not aware it needed to be posted. Severity: 1 Scope: 3		On Feb 15, 2023 the director posted the non-discrimination statement on a public view location in the facility. This is to comply with the state regulations.	