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
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	**4180 SIERRA MADRE DR, RENO, NEVADA ,89502**

(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 in your facility on 09/26/2024. 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 six Residential Facility for Group beds for elderly or disabled persons, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and four employee files were reviewed. The facility received a grade of D. Your facility has recieved a C or D grade for this inspection. 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 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:	0000		
0065 SS= F	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 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,	0065	1. To correct the required caregiving training deficiency, the identified employees completed their training October 1, 2024. 2. Required annual training will be scheduled at the beginning of the year for all employees. 3. Calendar of annual required training will be monitored. 4. The Facility Administrator is responsible for ensuring the plan of correction is implemented.	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
	inclusive, and sections 2 to 16 inclusive of this regulation 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) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 3 of 3 employees, working at the facility one year or greater, completed at least eight hours of annual Caregiver training (Employee #1, #2, and #4). Findings include: Employee #1 Employee #1 was hired by the facility as the Administrator with a start date of 05/01/2007. Employee #1's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. Employee #2 Employee #2 was hired by the facility as the Owner/caregiver with a start date of 05/01/2007. Employee #2's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 02/29/2020. Employee #4's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. On 09/26/2024 at 12:10 AM, the Owner/Caregiver confirmed Employee #1, #2, and #4 lacked documented evidence of eight hours of annual training for the care of elderly or disabled, including two hours of Tier 2 dementia training. Severity: 2 Scope: 3		5. Corrective action completed on October 1, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
0102 SS= F	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on personnel file review, document review, and interview, the facility failed to ensure tuberculosis (TB) screening was completed in accordance with Nevada Administrative Code 441A.375 for 3 of 4 employees (Employee #2, #3, and #4). Findings include: Employee #2 Employee #2 was hired by the facility as the Owner/caregiver with a start date of 05/01/2007. Employee #2's personnel file documented a negative QuantiFERON test dated 08/02/2023. Employee #2's personnel file lacked documented evidence of a TB test for 2024. Employee #3 Employee #3 was hired by the facility as a Caregiver with a start date of 07/20/2023. Employee #3's personnel file documented a negative QuantiFERON test dated 07/20/2023. Employee #3's personnel file lacked documented evidence of a TB test for 2024. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 02/29/2020. Employee #4's personnel file documented a TB signs and symptoms questionnaire for 2022 and 2023. Employee #4's personnel file lacked documented evidence of a TB signs and symptoms questionnaire for 2024. On 09/26/2024 at 12:10 PM, the Owner/Caregiver confirmed employee #2, #3 and #4 did not complete the TB testing requirements for 2024. Severity: 2 Scope: 3	0102	1. Employees with missing TB Testing results were scheduled to get tested first available appointment with respective PCP. 2. Annual TB testing for all employees will be scheduled on the annual anniversary of their last test. 3. Close monitoring of the employees' date of last TB Test. 4. The Facility Administrator is responsible for ensuring the plan of correction is implemented. 5. Corrective actions completed 11/18/24	11/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
0106 SS= F	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on personnel file review, document review, and interview, the facility failed to ensure 3 of 4 employees were trained in cardiopulmonary resuscitation (CPR) and first aid and maintained current certification. (Employee #1, #2, and #4). Findings include: Employee #1 Employee #1 was hired by the facility as the Administrator with a start date of 05/01/2007. Employee #1's personnel file documented CPR and first aid certification with expiration dated 05/2024. Employee #1's personnel file lacked documented evidence of current CPR and first aid certification. Employee #2 Employee #2 was hired by the facility as the Owner/Caregiver with a start date of 05/01/2007. Employee #2's personnel file documented CPR certification with an expiration date of 05/2026. Employee #2's personnel file lacked documented evidence of first aid training and certification. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 02/29/2020. Employee #4's personnel file documented CPR and first aid certification with expiration dated 04/2024. Employee #4's personnel file lacked documented evidence of current CPR and first aid certification. On 09/26/2024 at 120 PM, The Owner/Caregiver confirmed Employee #1 and #4 lacked current CPR and first aid training and Employee #2 lacked current first aid training. Severity: 2 Scope: 3	0106	1. Employees completed CPR Training. 2. Checklist of required annual training and certification monitored. 3. Consistent monitoring of checklist. 4. The Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action implemented 11/18/24.	11/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on clinical record review, document review and interview, the facility failed to develop a person-centered service plan addressing all required focus areas and interventions for 5 of 5 residents in the facility (Resident #1, #2, #3, #4, and #5). Findings include: The following residents lacked a person-centered service plan addressing all required the required elements during the residents' clinical record review: - Resident #1 was admitted to the facility on 02/14/2024, with diagnoses including hypertension, vitamin D deficiency, history of tubular adenoma, and benign prostatic hyperplasia. - Resident #2 was admitted to the facility on 11/19/2022, with diagnoses including atherosclerosis, Binswanger's dementia, chronic obstructive pulmonary disease, and major depressive disorder. - Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. - Resident #4 was admitted to the facility on 08/05/2021, with diagnoses including dementia associated with alcoholism, essential hypertension and emphysema. - Resident #5 was admitted to the facility on 02/02/2024, with diagnoses including cerebral atherosclerosis, chronic obstructive pulmonary disease, and right bundle branch lock. On 09/26/2024 at 11:35 AM, the Owner/Caregiver confirmed the facility lacked person-centered service plans for Resident #1, #2, #3, #4, and #5. Severity: 2 Scope: 3	0515	1. Baseline Care Plan created. 2. Will be used for all residents. Copy of each residents' care plan will be submitted. 3. Monthly review of the care plan for each resident will be conducted. 4. The Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action completed 10/28/24.	10/28/2024
0870	Medication Administration-Accuracy &	0870	1. Updated Six Months Medication Review	10/28/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
SS= F	Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and clinical record review, the Administrator failed to ensure a Pharmacy Profile Review was conducted by a physician, pharmacist or registered nurse for 4 of 5 residents in the facility longer than six months (Residents #2, #3, #4, and #5). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/19/2022, with diagnoses including atherosclerosis, Binswanger's dementia, chronic obstructive pulmonary disease, and major depressive disorder. Resident #2's clinical record documented a six month medication profile review dated 08/21/2024. Resident #2's clinical record lacked a six month medication profile review in February 2024 or later. Resident #3 Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. Resident #3's clinical record documented a six month medication profile review dated 09/17/2024. Resident #3's clinical record lacked a six month medication profile review in March 2024 or later. Resident #4		Form. 2. Will use updated form to review meds. 3. Will review semi-annually. 4. The Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Correction implemented 10/28/24.	4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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 08/05/2021, with diagnoses including dementia associated with alcoholism, essential hypertension and emphysema. Resident #4's clinical record lacked six month medication profile reviews for 2024. Resident #5 Resident #5 was admitted to the facility on 02/02/2024, with diagnoses including cerebral atherosclerosis, chronic obstructive pulmonary disease, and right bundle branch lock. Resident #5's clinical record lacked six month medication profile reviews for 2024. On 09/26/2024 at 12:10 PM, the Owner/Caregiver confirmed Resident #2, #3, #4, and #5 lacked pharmacy profile reviews for 2024. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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= E	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 2 of 4 residents residing in the facility for longer than six months (Resident #2 and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/19/2022, with diagnoses including atherosclerosis, Binswanger's dementia, chronic obstructive pulmonary disease, and major depressive disorder. Resident #2's clinical record documented a six month medication profile review dated 08/21/2024, lacked evidence of the Administrator's review and initials. Resident #3 Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. Resident #3's clinical record documented a six month medication profile review dated 09/17/2024, lacked evidence of the Administrator's review and initials. On 09/09/2024 at 11:42 AM, the Administrator confirmed the Administrator had not initialed the medication profile review dated 01/29/2024 for Resident #2 and #3, and verbalized the Administrator needed to review and initial the report within 72 hours. Severity: 2 Scope: 2	0874	1. Six Months Med Review Forms for all five residents have been signed by the administrator. 2. Will start using the updated form which contains the required Administrator Signature. 3. Will review every six months. 4. The Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Plan of correction completed 10/28/24.	10/28/2024
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver	0878	1. Physician order for PRN medication for Resident #3 is on file. 2. Ensure all residents' medications has physician orders on file.	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
	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 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.		3. Review physician orders on all medications for all residents. 4. The Facility Administrator is responsible for ensuring that plan of correction is implemented. 5. Corrective action completed 10/1/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
	Inspector Comments: Based on observation, clinical record review, document review and interview, the Administrator failed to ensure a physician's order was maintained by the facility for a resident's as needed medication for 1 of 5 residents in the facility (Resident #3). Findings include: Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. On 09/26/2024 at 12:48 PM, during Resident #3's medication review, Resident #3's medication box contained a medication bottle of Acetaminophen 500 milligrams (mg), take 1 tablet by mouth every six hours as needed (PRN) for moderate pain. The bottle fill quantity was 30 tablets on 04/12/2024. The bottle contained eight tablets on 09/26/2024. Resident #3's Acetaminophen 500 mg was not listed on Resident #3's Medication Administration Record (MAR) for September 2024, August 2024, July 2024, June 2024, May 2024, or April 2024. On 09/26/2024 at 12:48 PM, the Owner/Caregiver verbalized the Owner/Caregiver could not produce the physician's order for Resident #3's Acetaminophen 500 mg PRN prescription and confirmed the medication had been administered to Resident #3 since the prescription was filled on 04/12/2024. The facility policy titled "Medication Plan," undated, documented the Director would make sure all residents' medications had orders for all medications. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
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 5 residents in the facility (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. Resident #3's medications contained a a bottle of Atorvastatin 80 milligrams (mg), take one tablet by mouth every night. Resident #3's September 2024 Medication Administration Record (MAR) documented Atorvastatin 20 milligrams (mg), take one tablet by mouth every night. A Physician's Order dated 09/17/2024, documented Atorvastatin 20 milligrams (mg), take one tablet by mouth every night. On 09/26/2024 at 12:57 PM, the Owner/Caregiver verbalized the Resident #3's Atorvastatin medication strength had been changed from 80 mg to 20 mg and the Atorvastatin 80 mg container should have been removed from Resident #3's medications and destroyed. Severity: 2 Scope:1	0885	1. Discontinued medication for Resident #3 has been destroyed and documented. 2. Consistent check on all medications. 3. Review medication list for updates. 4. Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action implemented 10/01/24	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
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 document review, clinical record review and interview, the facility failed to ensure 1 of 5 residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A.375 (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/19/2022, with diagnoses including atherosclerosis, Binswanger's dementia, chronic obstructive pulmonary disease, and major depressive disorder. Resident #2's clinical record documented a negative QuantiFERON TB lab test dated 05/18/2021, and an annual one-step TB test given on 10/19/2023 at 12:47 PM, and read negative on 10/21/2023 at 1:50 PM. Resident #2's clinical record lacked documented evidence of a second step TB test for 2023. On 09/26/2024 at 11:37 AM, the Owner/Caregiver confirmed Resident #2 did not have an annual TB test in May 2022, and verbalized Resident #2 needed a second step TB in 2023. Severity: 2 Scope: 1	0936	1. TB Test result for Resident #2 on file. 2. Diligence in checking annual TB Testing for all residents. 3. Check all residents' chart for required annual TB testing completion. 4. The Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action implemented on 10/15/24	10/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
0950 SS= D	Hospice Care Responsibilities of Staff - NAC 449.275 Residential facility which provides residents with hospice care: Responsibilities of staff; retention of resident with special medical needs. (NRS 449.0302) 1. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to NAC 449.0186 for that resident. Inspector Comments: Based on observation, clinical record review and interview, the facility failed to ensure a hospice Plan of Care was obtained and retained by the facility for a resident receiving hospice care for 1 of 1 hospice residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 02/02/2024, with diagnoses including cerebral atherosclerosis, chronic obstructive pulmonary disease, and right bundle branch lock. On 09/26/2024 at 12:01 PM, the Owner/Caregiver confirmed Resident #5 was receiving hospice care from an outside agency and the facility did not have the resident's Plan of Care upon request from the State Survey Agency. Severity: 2 Scope: 1	0950	1. Hospice Plan of Care for Resident #5 on file. 2. Communicate with Hospice Provider regarding Plan of Care. 3. Diligence in checking documentations of plan of care. 4. Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action implemented 10/01/24	10/01/2024
1600 SS= C	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name	1600	1. Created Policy on Preferred Name/Pronoun P & P RO 16-20 Sec. 19 1. 2. Immediate implementation of the policy. 3. Conducting resident chart review. 4. The Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action implemented 10/01/24.	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	**4180 SIERRA MADRE DR, RENO, NEVADA ,89502**

(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
	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. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on observation, clinical record review and interview, the facility failed to ensure there			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
	were policies developed and resident records in compliance with Legislative Counsel Bureau File Number R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation for 5 of 5 residents in the facility (Resident #1, #2, #3, #4, and #5). Findings include: The following residents' records lacked the inclusion of a resident's choice to provide the resident's preferred name, pronoun, gender identity or expression, and sexual orientation: - Resident #1 was admitted to the facility on 02/14/2024, with diagnoses including hypertension, vitamin D deficiency, history of tubular adenoma, and benign prostatic hyperplasia. - Resident #2 was admitted to the facility on 11/19/2022, with diagnoses including atherosclerosis, Binswanger's dementia, chronic obstructive pulmonary disease, and major depressive disorder. - Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. - Resident #4 was admitted to the facility on 08/05/2021, with diagnoses including dementia associated with alcoholism, essential hypertension and emphysema. - Resident #5 was admitted to the facility on 02/02/2024, with diagnoses including cerebral atherosclerosis, chronic obstructive pulmonary disease, and right bundle branch lock. On 09/26/2024 at 11:40 AM, the Owner/Caregiver confirmed there were no changes to residents' clinical records in compliance with the regulation. Severity: 1 Scope: 3			
1700 SS= E	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which	1700	1. Residents #1 and #3's Initial Standard Physician Assessment and Placement Determination obtained and on file. 2. Ensure that Initial Assessment and Placement determination is completed upon admission. 3. Required documents must be complete upon admission to the facility. 4. Facility Administrator is responsible for ensuring plan of correction is implemented. 5. Corrective action implemented 10/22/24	10/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	**4180 SIERRA MADRE DR, RENO, NEVADA ,89502**

(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 include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review, document review, and interview, the facility failed to obtain an appropriate initial Standard Physician Assessment and Placement Determinations for a resident's placement in the facility for 2 of 5 residents (Resident #1 and #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/14/2024, with diagnoses including hypertension, vitamin D deficiency, history of tubular			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
	adenoma, and benign prostatic hyperplasia. Resident #1's clinical record documented a Standard Placement Determination dated 02/13/2024, marked by the physician as the resident needed to be placed in a residential facility to care for residents with Alzheimer's disease equipped with wander control systems in place. Resident #3 Resident #3 was admitted to the facility on 11/03/2023, with diagnoses including diabetes, dementia, failure to thrive and hypothyroidism. Resident #3's clinical record documented a Standard Placement Determination dated 11/02/203, marked by the physician as the resident needed to be placed in a residential facility to care for residents with Alzheimer's disease equipped with wander control systems in place. On 09/26/2024 at 11:44 AM, the Owner/Caregiver verbalized Resident #1 and #3 were safe in the facility and confirmed Resident #3's and #6's Standard Physician Assessment and Placement Determination was not correctly marked and the Caregiver should have clarified with the residents' provider. Severity: 2 Scope: 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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
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. Inspector Comments: Based on personnel file review, document review, and interview, the facility lacked a designated primary and secondary infection control person with the required infection control training per Legislative Counsel Bureau File Number R048-22, Section 5, with the potential to affect 5 of 5 residents. Findings include: On 09/26/2024 at 12:00 PM, the Owner/Caregiver confirmed the required infection control and prevention training had not been completed by Employee #1, the primary infection control person for the facility, and Employee #2, the secondary infection control person for the facility. Severity: 2 Scope: 3	1830	1. The primary and secondary infection control persons has completed the required Infection Control Training for 2024. 2. Employee Checklist for required training and certification. 3. Continued update on employee checklist. 4. Facility Administrator is responsible for ensuring that plan of correction is implemented. 5. Corrective action implemented on 12/10/24	12/10/2024
1840 SS= F	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must	1840	1. Employees #4 have completed required 6 topics of Infection Control Certification. Employee #3 no longer works for the facility. 2. Employee Checklist have been implemented. 3. Continued update on employee checklist. 4. Facility Administrator is responsible for	12/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5523	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOME ADULT LIVING	4180 SIERRA MADRE DR, RENO, NEVADA ,89502

(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, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 2 of 2 employees obtained the required infection control training required per Legislative Counsel Bureau File Number R063-21, Section 4 with the potential to affect 5 of 5 residents (Employees #3 and #4). Findings include: Employee #3 Employee #3 was hired by the facility as a Caregiver with a start date of 07/20/2023. Employee #3's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 02/29/2020. Employee #4's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. On 09/26/2024 at 12:00 PM, the Owner/Caregiver acknowledged the lack of documented evidence of required infection control training in the personnel files for Employee #3 and #4. The Owner/Caregiver verbalized the infection control training had not occurred. Severity: 2 Scope: 3		ensuring plan of correction is implemented. 5. Corrective action implemented 12/10/24. OHAL Infection Prevention and Control Plan uploaded.	