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
	7414	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA MANOR CARE HOME	**327 RIVER FLOW DRIVE, RENO, NEVADA ,89523**

(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 a State Licensure annual grading survey conducted in your facility on 07/13/20. 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 eight Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illness, mental illness, or intellectual disabilities, three Category I residents, and five Category II residents. The census at the time of the survey was seven. Seven resident files and six employee files were reviewed. The facility received a grade of A. 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 deficiency was 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: LAILA BUENVIAJE Title: Administrator Date: 08/06/2020

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0178 SS= D	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 a window screen was well-maintained and a table in the backyard for resident use did not have splintered wood and peeling paint. Findings include: On 07/13/20 at 9:40 AM during a tour of the facility grounds a screen on the back of the house, covering the living room window, was bent and detached from the frame. A round table in the backyard next to the back door ramp was splintered along the edge and the paint was peeling on the top of the table. On 07/13/20 at 12:28 PM, the Administrator verbalized the screen was in disrepair and the table was splintered and had peeling paint. Severity: 2 Scope: 1	0178	1. We hired a repair man to fix the screen on the back of the Facility. Caregivers were told to report anything broken in the Facility so it will be fixed especially if it's an environmental hazard. The table in the backyard was disposed. 2. A log for maintenance and repair for the Facility was made to know which part needs to be fixed and to be done right away. 3. We will inspect the exterior of the Facility every month to check if anything needs repair and make sure that maintenance will be done to ensure that the Facility is a safe environment for the residents and staff. 4. The Administrator, Manager and Caregivers. 5. The screen was fixed on 07/20/2020 and the table was disposed on 07/13/2020. Please see attached pictures.	07/20/2020

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0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 07/13/20 at 9:56 AM, during a facility tour, resident room #2 had two unsecured oxygen tanks in the closet. On 07/13/20 at at 9:58 AM, the caregiver confirmed the oxygen tanks were unsecured in the closet and verbalized the oxygen tanks were to be kept in a rack. Severity: 2 Scope: 1	0690	1. Training was given to the Caregivers on how to properly store oxygen tanks. Oxygen tanks should be secured in a rack upon delivery to the facility. 2. The caregiver will store the oxygen tank by placing them secured in a rack once delivered to the facility. Another caregiver will double check that the tanks are stored properly. 3. Oxygen tanks will be checked every month or after delivery of Oxygen tank to ensure proper storage. 4. The Owner or Administrator will routinely check the oxygen tank storage for compliance. 5. Corrected on the day of survey on 07/13/2020. Please see attached picture.	07/13/2020

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0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the physician. If a physician 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 (Previously Y 0879) (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 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, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review, and interview, the failed to ensure a medication was on-site to administer as prescribed for 1 of 7 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 06/08/19, with diagnosis	0878	Bisacodyl was found in the bucket where medications are kept. It was at the very end almost sticking to the bucket that it was overlooked during the survey. 1. Training was given to the Caregivers that medication should be ordered a week before the last dose on hand. 2. We will do inventory of the resident's medications and keep the medicine properly so it can easily be found. 3. Medications will be routinely checked every month to ensure that all Residents have enough medications on hand. 4. The Caregiver and Administrator. 5. The medication was found by the Administrator in the bucket of the Resident after the survey on 08/13/20. Please see attached picture.	07/13/2020

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	including chronic hypoxia. A physician order and the Medication Administration Record for Resident #3 documented, Bisacodyl 10 milligram suppository, unwrap and insert one suppository per rectum daily, as needed for constipation. However, during a review of medications the Bisacodyl was not available. On 07/13/20 at 11:14 AM, the Caregiver confirmed the medication was not available on-site. Severity: 2 Scope: 1			