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
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	**1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408**

(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 survey conducted in your facility on 07/29/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 72 Category II, Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's Disease. The census at the time of the survey was 32. Ten resident files and nine 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 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: LAURA HIGMAN	Title: Designated Manager	Date: 09/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
0051 SS= C	Administrator's Responsiblities - Designation - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. Inspector Comments: Based on observation, interview and document review, the facility failed to designate in writing one or more employees to oversee the facility during the Administrator's absence. Findings include: On 07/29/21 at 10:02 AM, during the facility tour there was no evidence of a written posted designation of the employee(s) in charge during the Administrator's absence. On 07/29/21 at 10:29 AM, the Designated Manager acknowledged there was no document posted or available identifying who was the designee to be contacted in the Administrator's absence. The Designated Manager confirmed the designee contact information posted on the wall was the community phone number. Severity: 1 Scope: 3	0051	On8/24/21, a document was created and posted in the community of a designated employee that will oversee the facility during the Administrator’s absence. If there is a change to these designations, the Designated Manager and/or the Administrative Assistant will ensure information is up to date going forward and is reviewed monthly or upon change. Please see attachment A.	08/24/2021
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide	0074	Employee#3- Elder Abuse Training was completed on 8/18/21 during All-Staff meeting. Please see attachment B. Employee #5- Abuse and Neglect	08/18/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	**1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408**

(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
	personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing		training was completed on2/19/20 (attachment C), however, training was not Nevada specific as requested by inspector. Nevada specific training completed on 4/26/21 as stated in SOD. Going forward, Nevada Specific Elder Abuse Training will be completed for every employee upon hire and annually. A spreadsheet and file tracking form was created on 8/24/21. Please see attachment D. Employee files will be re-organized using the tracking form by 9/10/21. The Administrative Assistant will oversee that training is completed for all employees and all files will be reviewed monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	**1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408**

(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
	the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on employee record review and interview, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
	Administrator failed to ensure 2 of 9 sampled employees completed training to recognize and prevent the abuse of older persons within the required timeframes. Findings include. The following employee records lacked documented evidence of training to recognize and prevent the abuse of older persons: Employee #3 Employee #3 was hired as the Wellness Director on 09/16/19. The personnel file for Employee #3 documented annual elder abuse prevention training was last completed on 05/12/20. The employee's file lacked documented evidence annual elder abuse training had been completed for 2021. On 07/29/21 at 2:02 PM, the Designated Manager confirmed Employee #3 should have completed annual elder abuse training by 05/12/21 and the employee had not completed the training. Employee #5 Employee #5 was hired as the Director of Environmental Services on 06/20/17. The employee's personnel file documented annual elder abuse prevention training last completed on 04/26/21, however, the employee's file lacked documented evidence of annual elder abuse prevention training completed in 2020. On 07/27/21 at 12:58 PM, the Designated Manager confirmed Employee #5 had not taken annual Elder Abuse Training in 2020. Severity: 2 Scope: 1			
0102 SS= D	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 employee record review and interview, the facility failed to ensure tuberculosis (TB) screenings were completed within the required timeframe for 3 of 9 employees (Employee #5, #6, and #7), and pre-employment physicals examinations were completed for 5 of 9 employees (Employee #7, #2, #9, #3, and #4). Findings include. The following employee records lacked	0102	Employee#5- last TB test on 9/21/20 which was given late. A QuantiFERON blood draw was taken 8/24/21 to ensure test is within the one-year requirement, facility waiting for results. Employee #6- On 9/26/20employee's QuantiFERON TB test results were read as negative (given late). Please see attachment E. Employee is scheduled to complete an annual TB QuantiFERON on 8/26/21. Employee #7- although TB results were not on file at the facility-	08/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
	documented evidence TB screenings were completed within the required timeframe: -Employee #5 was hired as the Director of Environmental Services on 06/20/17. Employee #5's record documented a QuantiFERON laboratory TB test read negative on 05/08/19 and a QuantiFERON laboratory TB test read negative on 09/21/20. The resident's TB test was four months late in 2020. On 07/29/21 at 12:58 PM, the Designated Manager confirmed the annual TB test for Employee #5 was given late. -Employee #6, with a start date of 07/01/14, was hired as a Medication Aide. Employee #6's previous one-step TB screening documented a read date of 05/29/20. The screening lacked any documented test result. Employee #6's record lacked a completed TB screening for 2020 or 2021. -Employee #7, with a start date of 03/09/21, was hired as a Medication Aide. Employee #7's previous TB screening was QuantiFERON Gold dated 12/16/19, with a negative result. Employee #7's record lacked a completed TB screening for 2020 or 2021. On 07/29/21 at 1:03 PM, the Designated Manager confirmed Employee #6 and #7 lacked current TB screening. The following employee records lacked documented evidence a pre-employment physical exam was completed: Employee #7 Employee #7, with a start date of 03/09/21, was hired as a Medication Aide. Employee #7's record lacked documented evidence a pre-employment physical exam was completed prior to caring for residents. Employee #2 Employee #2 was hired as a Designated Manager with a start date of 01/04/21. The employee file lacked documented evidence of a pre-employment physical examination. On 07/29/21 at 1:43 PM, the Designated Manager confirmed the missing documentation and could not provide a pre-employment physical examination for 2021 available for review during the onsite survey. Employee #9 Employee #9 was hired as a Resident Assistant on 01/28/21. Employee #9's Employment Physical & Medical Questionnaire dated 01/08/21 lacked documented evidence the employee was free from any other contagious disease. On 07/29/21 at 2:04 PM, the Administrator		results were retrieved and placed in file on 7/29/21 prior to exit of inspectors. Employee #7's TB draw was collected 3/1/21 and read on3/3/21. Please see attachment F. Employee #7- although documentation of physical was not on file at facility- results were retrieved and placed in file on 7/29/21. Please see attachment G. Employee #2- physical completed on8/10/21. Please see attachment H. Employee #9 and Employee #4- facility will be complete a more thorough review of pre-employment physicals to ensure all required information has been completed by physician. Employee #3- employee was re-hired on 9/16/19, however, facility used previous pre-employment physical. Going forward, all re-hires will be treated as new hires. The Administrative Assistance will oversee all pre-employment physicals, TB testing, and that all files will be reviewed monthly. A tracking form was created 8/24/21 and forms will be completed and placed in employee files. Please see attachment I. The Administrative Assistant will ensure all new team members' physical documentation of physicals and TB test results will be reviewed to ensure proper evidence of pre-employment physicals and screening of communicable diseases. If the proper documents do not state the new team member is clear of communicable diseases,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
	confirmed the box on the physical was not marked to indicate the employee was free from any other contagious disease. Employee #3 Employee #3 was hired as the Wellness Director on 09/16/19. Employee #3's Employment and Medical Clearance document (physical exam) was signed and dated by the provider on 03/12/18. Employee #4 Employee #4 was hired as the Director of Life Enrichment on 12/22/20. Employee #4's physical exam, dated 12/28/20, lacked documented evidence the employee was free from contagious disease. On 07/29/21 at 2:02 PM, the Designated Manager (DM) confirmed the pre-employment physical exam for Employee #3 had been completed more than one year prior to the employee's start date. The DM confirmed the physical exam for Employee #4 lacked documented evidence the employee was free from contagious disease. The facility's policy titled, "Health Services-Infection Control, Tuberculosis," documented the Administrator, Wellness Director and/or Licensed Nurse are responsible to establish and manage processes in the Community for infection control according to all regulations that apply. Team members and residents must meet designated testing and immunization requirements related to infectious disease. Severity: 2 Scope: 1		we will immediately contact the medical facility to provide Fernley Estates with the correct paperwork. New hire orientation will not be scheduled for that individual until the correct documents are in our possession.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
0104 SS= A	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 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: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on employee record review and interview, the facility failed to maintain a complete list of current employees on the established Internet website for criminal history checks for 1 of 9 sampled employees (Employee #1). Findings include. The facility's Nevada Automated Background Check System (NABS) account lacked documented evidence the following employee had been entered into the facility's account using the Internet website. -Employee #1 with a start date of 11/01/18, and the current title of Administrator. Employee #1's record documented fingerprints were submitted on 02/23/18 and a NABS clearance letter was dated 03/07/18. On 07/29/21 at 1:51 PM, the Administrator confirmed the Administrator had not been entered into the facility's NABS account using the Internet website. Severity: 1 Scope: 1	0104	Employee#1 fingerprints have been associated with the facility as of 8/23/21. Please see attachment N. Going forward, the Administrative Assistant will oversee all new hire paperwork to ensure fingerprints and background checks are completed and entered into the NABS account properly.	08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
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 cushioned bench located in the dining area of the memory care unit was in good repair for use by 10 of 10 residents residing in the memory care unit. Findings include: On 07/29/21 at 9:33 AM, a cushioned bench in the dining area of the memory care unit had ripped and torn material on the seat, exposing the cushion. An approximately one foot by one foot area on the bench seat was missing the upholstery. On 07/29/21 at 9:34 AM, the Designated Manager confirmed the seat of the bench had torn and missing material and should not have been in a resident use area until the bench was repaired. Severity: 2 Scope: 1	0178	Cushionedbench with torn material located in memory care was removed before end of dayon 7/29/21. The environmental service director will ensure all furniture is ingood working order and will walk the entire community weekly.	07/29/2021
0220 SS= E	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on	0220	Memory care laundry room was cleaned 7/29/21 before end of day. Memory care laundry room cleaning has been added to the housekeeping weekly cleaning list. This will be monitored by the environmental service director. New cleaning schedules will be created by 8/3/21 and put into place on 8/6/21. Due to the limited amount of spacein the memory care laundry room; dirty laundry will not be stored in thelaundry room. Laundry will only be pulled from apartments when clothes areready to go directly into the washing machine. Clean laundry will be folded on the counter outside of the laundry room,and the counter will be disinfected after each use and on every shift. Trainingfor this new policy and procedure will be conducted on Friday 8/27/21 andposted in the laundry room. The Wellness Director will oversee to ensure properprocedures are being	07/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
	observation, interview, and document review the facility failed to ensure the laundry room in the memory care unit was free of lint and debris on the floor, on surfaces in the rooms, and behind the washer and dryer, and soiled and clean laundry were separated. Findings include: On 07/29/21 at 9:23 AM, the laundry room in the memory care unit had lint and debris on the floor, a layer of lint was on the top of both the washer and dryer, and lint was covering the back of the dryer. The floor between the back of the dryer and the wall had clumps of lint, an empty dryer sheet box made of cardboard, two rolls of toilet paper, and three plastic bags. A basket containing laundry was located on the floor in front of the dryer. Resident clothing items were hanging from a wire rack above the basket of laundry. On 07/29/21 at 9:25 AM, the Designated Manager (DM) confirmed the laundry room had lint on the floor and surfaces of the washer and dryer and the back of the dryer was coated in a layer of lint. The DM confirmed the floor between the back of the dryer and the wall had lint, toilet paper, an empty dryer sheet box, and plastic bags. The DM verbalized the laundry room should have been cleaned and it was not safe for the items to be behind the dryer. The DM verbalized the basket of laundry on the floor appeared to have not yet been laundered. The facility policy titled, "Laundry Policy," dated 06/24/21, documented soiled laundry would be kept separate from clean laundry and surfaces would be disinfected if the surface had come into contact with soiled laundry. Severity: 2 Scope: 2		followed. Please see attachment J.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
0870 SS= A	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 record review and interview, the Administrator failed to initial a medication profile review for 1 of 10 sampled residents (Resident #7). Findings include. Resident #7 Resident #7 was admitted to the facility on 07/17/20, with diagnoses including depression, pain, hypertension, and constipation. Resident #7's medication profile review dated 01/16/21, lacked documented evidence of the Administrator or the Administrator's designee's initials confirming the profile had been reviewed. On 07/29/21 at 11:01 AM, the Designated Manager confirmed Resident #7's medication profile review dated 01/16/21, was not initialed by the Administrator. The Designated Manager could not confirm if the medication profile had been reviewed. Severity: 1 Scope: 1	0870	The pharmacy review conducted on 7/15/21 was completed for all residents which was reviewed and signed by the pharmacist and the designated manager within 3 days. Going forward, the Designated Manager will ensure all residents on the facility's medication program is reviewed by the pharmacist and signed by the administrator and/or Designated Manager within the regulation time period of 3days.	07/15/2021
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	0936	Resident #3 and#4- although TB tests were late, both residents are up to date as of 2/11/21and 5/27/21. To ensure all residents receive their	07/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	**1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408**

(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
	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 2 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441a (Resident #4 and #3). Findings include: Resident #4 Resident #4 was admitted to the facility on 05/08/19, with diagnoses including Parkinson's disease, hypertension and hypothyroidism. Resident #4's record documented a QuantiFERON laboratory TB test read negative on 12/12/19 and a QuantiFERON laboratory TB test read negative on 02/11/21. The resident's TB test was two months late. On 07/29/21 at 11:37 AM, the Designated Manager and Wellness Director confirmed the annual TB test for Resident #4 was given late. Resident #3 Resident #3 was admitted to the facility on 05/27/21, with diagnoses including heart failure, gout, dementia, hypertension, chronic kidney disease, and chronic left fourth toe osteomyelitis. A QuantiFERON Gold TB Test result dated 06/17/21, documented a negative result. The test was documented completed 20 days after the Resident #3 was admitted to the facility. On 07/29/21 at 10:59 AM, the Designated Manager confirmed Resident #3's TB screening had not been completed within the required five days after admission. The facility's policy titled, "Health Services-Infection Control, Tuberculosis," documented the Administrator, Wellness Director and/or Licensed Nurse are responsible to establish and manage processes in the Community for infection control according to all regulations that apply. Team members and residents must		TB tests within 5 days of move in and annually; the wellness director will coordinate directly with the resident's provider and/or family members to obtain a written order for the test and test is conducted. The wellness director created a spreadsheet for all residents that documents last date of test and will monitor monthly and schedule tests as needed. Please see attachment K.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
	meet designated testing and immunization requirements related to infectious disease. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation, interview, and document review, the failed to ensure residents were safe from toxic substances for 10 of 10 residents residing in the memory care unit. Findings include: On 07/29/21, during a tour of the memory care unit between 9:08 AM and 9:40 AM, the following toxic substances were observed in the facility: - Antimicrobial lotion soap was in wall mounted dispensers in all resident bathrooms and in the unlocked, staff and visitor restroom on the unit. - One eight ounce bottle of alcohol based hand sanitizer was located in an unlocked, clear, plastic drawer on the laundry folding station. The Safety Data Sheet from the antimicrobial lotion soap distributor, revised 02/24/14, documented the soap had the potential to cause serious eye damage. On 07/29/21 at 9:28 AM, the Designated Manager (DM) verbalized the alcohol based hand sanitizer should not have been in a clear, unlocked drawer accessible to the residents in the memory care unit. On 07/29/21 at 11:40 AM, the DM verbalized the resident's in the memory care unit had not been assessed for the ability to properly use the soap in the wall mounted dispensers and were not continuously monitored to ensure proper use of the soap. The facility policy titled, "Memory Care - Introduction: Hazardous Items," dated 01/20/20, documented all toxic substances were not accessible to the residents of the facility and would be stored in locked cabinets or locked areas. Items used for daily use, such as soap, would be allowed in resident rooms if the resident had demonstrated proper use of the items or was monitored during the use of the products. Severity: 2 Scope: 3	0999	On 7/29/21 after further inspection, facility discovered the Buckeye Symmetry Green Certified Foaming Hand Wash that is located inside the soap dispensers throughout memory care appears to be safe for residents in memory. Please review the letter from the manufacturer and the SDS sheet as attachment L. On page 4 of the SDS, the toxicological information states the product information does not present a hazard therefore, resident demonstration of proper soap handling is not needed. Hand sanitizer was removed immediately at time of inspector visit. Going forward, the wellness director and/or environmental service director will complete weekly sweeps of common areas and apartments in memory care to ensure all hazardous items are not accessible to residents. Upon move-in and the following assessment schedule; every memory care resident will demonstrate proper hand washing procedures. This will be documented in the care plan. If a resident cannot demonstrate proper procedures, the residents care plan will require standby assistance for all grooming activities. The wellness director will ensure that this item is documented in the care plan by 10/8/21 and immediate for all new residents.	07/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
1037 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on employee record review and interview, the Administrator failed to ensure an employee had completed the required hours of continuing education in providing care to residents with dementia for 1 of 9 sampled employees (Employee #1). Findings include: The following employee record lacked documented evidence of the required hours of continuing education in providing care to residents with dementia: Employee #1's record documented a start date of 11/01/18, and a current title of	1037	Afterfurther review, Employee #1’s required 3 hours of dementia training wascompleted on 1/1/21, 2/1/21, and 3/1/21.However, documentation was notavailable during time of review. Documentation was brought to facility on8/2/21. Please see attachment M. Goingforward, Administrative Assistant will ensure all required trainings arecompleted and up to date for all employees using tracking spreadsheets. Pleasesee attachment D.	08/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

(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
	Administrator. Employee #1's previous dementia care training was completed on 05/03/20. Employee #1's record lacked documented evidence of dementia care training in 2021. On 07/29/21 at 2:08 PM, the Administrator confirmed the Administrator had not completed the dementia training in 2021. Severity: 2 Scope: 1			