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 _____	09/14/2023

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 9/14/23, 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 48. 15 resident files and 10 employee files were reviewed. The facility received a grade D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0074 SS= E	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 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	0074	1. Employee #2's elder abuse was completed on 5/17/23 and the employee is no longer employed. Employee #3's elder abuse was completed on 5/17/23. Employee #7's elder abuse was completed on 9/6/23 with her first day on the floor on 9/10/23. Employee #14's elder abuse was completed on 9/14/23. 2. An audit has been completed of all team member files and all initial and annual elder abuse has been completed. 3. All new employee files are audited prior to the employee working on the floor by the	09/14/2023

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	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 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,		Administrator. All annual training will be audited monthly by the administrator. 4. The administrator is responsible for ensuring these goals are met. 5. 09/14/2023	

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	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 personnel file review and interview, the Administrator failed to ensure 4 of 15 employees received initial elder abuse training prior to beginning work at the facility and annually, thereafter (Employee #2, #3, #7 and #14). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel			

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	Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Medication Aide with a start date of 05/04/23. Employee #2's personnel file contained an elder abuse training certificate dated 05/17/23. Employee #3 Employee #3 was hired by the facility as Medication Aide with a start date of 03/05/23. Employee #3's personnel file contained an elder abuse training certificate dated 05/17/23. Employee #7 Employee #7 was hired by the facility as Dietary Aide with a start date of 09/05/23. Employee #7's personnel file contained an elder abuse training certificate dated 09/09/23. Employee #14 Employee #14 was hired by the facility as Dietary Aide with a start date of 09/16/22. Employee #14's personnel file lacked an elder abuse training certificate. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2			

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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 record review and interview, the facility failed to ensure 2 of 15 employees met the requirements concerning tuberculosis (TB) testing (Employee #1 and #14). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 10/01/22. Employee #1's personnel file contained a TB QuantiFERON test dated 10/01/21 and a TB QuantiFERON test dated 11/18/22. Employee #14 Employee #14 was hired by the facility as Dietary Aide with a start date of 09/16/22. Employee #14's personnel file contained a TB QuantiFERON test dated 06/14/23. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0102	1. Annual TB Test was completed for employee #1, however it was late. Employee #14 completed the TB test upon hire, however the clinic lost the first vial. The first vile was taken on 6/8/23 (same day as the physical). The 2nd vile was taken on 6/14/23 and results came in on 6/15/23 as negative and this is attached. 2. An audit has been completed and all initial and annual TB tests have been updated. 3. The TB tracker will be reviewed monthly to ensure all employees complete their TB test on time. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023
0450 SS= E	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training.	0450	1. Employee #2, #3, #11, and #12 have all received CPR/First Aid, however they were late. 2. An audit has been completed and all CPR/First Aid certificates have been updated or completed. 3. The CPR tracker will be reviewed monthly to ensure all employees complete their CPR/First within 30 days of hire and prior to their expiration date. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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	Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 4 of 15 employees had the required cardiopulmonary resuscitation (CPR) and first aid training within 30 days of hire (Employee #2, #3, #11, and #12). On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Findings include: Employee #2 Employee #2 was hired by the facility as Medication Aide with a start date of 05/04/23. Employee #2's personnel file contained CPR and first aid training dated 07/07/23. Employee #3 Employee #3 was hired by the facility as Medication Aide with a start date of 03/05/23. Employee #3's personnel file contained CPR and first aid training dated 07/07/23. Employee #11 Employee #11 was hired by the facility as Resident Aide with a start date of 10/02/17. Employee #3's personnel file contained CPR and first aid training dated 06/17/21 and 07/07/23. Employee #12 Employee #12 was hired by the facility as Resident Aide with a start date of 03/29/23. Employee #12's personnel file contained CPR and first aid training dated 07/07/23. On 09/11/23 at 1:07 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 09/11/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2			
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical	0859	1. Residents #4, #7, #13, and #9 have updated physical examinations in their file. 2. An audit has been completed and any resident missing a physical exam has an appointment to get one completed. 3. Monthly and upon new resident move in the physical examination tracker will reviewed to ensure compliance with annual physical exams. 4. The wellness director is responsible for	10/17/2023

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	examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure a physical examination was completed prior to admission or annually for 4 of 15 residents (Resident #4, #7, #13, and #9). Findings include: Resident #4 Resident #4 was admitted to the facility on 02/28/23, with diagnosis including Parkinson's disease, dementia, and chronic pain. Resident #4's clinical record lacked documented evidence of a physical examination completed prior to admission to the facility. On 09/14/23 at 1:20 PM, the Administrator confirmed the resident's initial physical examination was not located in the resident file. Resident #7 Resident #7 was admitted to the facility on 10/01/21, with diagnosis including dementia, hypertension, and hypothyroidism. Resident #7's clinical record lacked documented evidence of an annual physical examination with a review of systems for 2023. On 09/14/23 at 1:45 PM, the Administrator confirmed the Resident #7's record lacked documented evidence of a physical examination completed annually. Resident #13 Resident #13 was admitted to the facility on 08/17/22, with diagnoses including depression, Alzheimer's, Parkinson's disease, hypertension, and anxiety. Resident #13's clinical record lacked documented evidence an initial general physical exam with a review of systems was completed in 2022. On 09/14/23 at 3:35 PM, the Administrator confirmed Resident #13's clinical record lacked documented evidence an initial general physical examination was completed. Resident #9 Resident #9 was admitted to the facility on 03/30/22, with diagnoses including chronic obstructive pulmonary disease, hypertension gastroesophageal reflux disorder (GERD), and irritable bowel syndrome (IBS). Resident #9's clinical record lacked documented evidence an initial general physical exam with a review of systems was completed in 2022. On 09/14/23 at 4:06 PM, the Administrator confirmed Resident #9's		ensuring these goals are ment. 5. 10/17/23	

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	clinical record lacked documented evidence an initial general physical examination was completed. Severity: 2 Scope: 1			
0874 SS= D	Medication Administration-Report Received - NAC 449.2742 - 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 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 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 by the resident's physician and initialed by the Administrator within 72 hours for 1 of 10 sampled residents residing in the facility for longer than six months (Resident #8). Findings include: Resident #8 was admitted to the facility on 10/15/20, with diagnoses including dementia, diabetes mellitus type II, chronic kidney disease, and left sided weakness. Resident #8's clinical record documented pharmacy reviews were completed on 01/11/23, and 07/07/23. The pharmacy review dated 07/07/23, documented a pharmacist recommendation related to the prolonged use of Protonix, a proton pump inhibitor and required a response from the prescriber. The provider's response, signature, and the date were left blank. The document was signed by the Administrator but was not dated. On 09/14/23 at 1:11 PM, the Administrator confirmed the prescriber did not acknowledge, review, or sign the document and the facility did not make any additional attempts to contact the prescriber. The Administrator confirmed the form was not dated to indicate when the Administrator signed the form. Severity 2 Scope 1	0874	1. Resident #8 has an updated medication review. 2. An audit has been completed of all resident charts and any past due reviews have been scheduled to be completed. 3. The 180 day order recaps tracker will be reviewed monthly and upon new resident move ins. 4. The wellness director is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were kept secured in the facility for 1 of 10 sampled resident (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/31/23, with diagnoses including leukocytosis and failure to thrive. On 09/14/23 at 2:15 PM, a bottle of acetaminophen, 500 milligram (mg) caplets was found on the bedside table in Resident #1's room. On 09/14/23 at 2:16 PM, the Wellness Director confirmed the bottle was being stored unsecured in a resident room and should have been stored in a locked/secured area. Severity 2 Scope 1	0920	1. The unsecured medication for resident #1 was secured after survey. 2. Resident apartments have been audited to ensure all medications are secured. 3. Weekly audits will be completed by the care team and turned in to the wellness director to ensure all medications are secured. An example of the audit form is attached. 4. The wellness director is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 02/28/23, with diagnosis including Parkinson's disease, dementia, and chronic pain. Resident #4's file contained a one-step TB test administered on 02/18/23, however, the test lacked a read date. The resident's record lacked documented evidence of a 2nd step TB test upon admission. On 09/14/23 at 1:21 PM, the Administrator confirmed Resident #4 lacked evidence of a 2nd step TB test upon admission. Severity: 2 Scope: 1	0936	1. Resident #4 was hospitalized on 10/15/23 and will not be returning to the community. 2. An audit has been completed of all resident charts and any missing or past due TB tests have been scheduled to be completed. 3. The TB test tracker will be reviewed monthly and upon new resident move in to ensure the community stays in compliance. 4. The administrator is responsible for ensuring these goals are met. 5. 10/15/23.	10/15/2023

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0938 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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 10 residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted on 08/17/20, with diagnoses including demntia, anxiety, depression, hypertension, peripheral vascualr disease, and polyneuropathy. Resident #10's clinical record documented a completed ADL assessment dated 06/07/22. Resident #10's clinical record lacked documented evidence an ADL assessment had been completed since 06/07/22. On 09/14/23 at 4:06 PM, the Administrator confirmed an annual ADL assessment was not completed for Resident #10 in 2023. Severity: 2 Scope: 1	0938	1. The ADL assessment for Resident #10 was completed on 8/4/20 and is attached. 2. All ADL assessments will be completed based on the company policy. 3. The administrator will monitor due dates of assessments to ensure all are completed in a timely manner. 4. The administrator is responsible for ensuring these goals are met. 5. 9/14/23	09/14/2023

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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 interview and document review, the facility failed to ensure a hospice Plan of Care was was obtained and retained by the facility for a resident receiving hospice care for 1 of 10 sampled residents (Resident #13). Findings include: Resident #13 Resident #13 was admitted to the facility on 08/17/22, with diagnosis including Parkinson's disease, depression, hypertension, anxiety, and Alzheimer's. On 09/14/23 at 1:26 PM, the Administrator confirmed Resident #13 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. The hospice care plan was received for Resident #13 and is attached. This was received during survey on 9/14/23. 2. All resident charts have been audited for hospice care plans if applicable. Contact has been made with the appropriate hospice company if a new one is needed. 3. The Hospice tracker will be reviewed quarterly and inconjunction with their ADL assessment due date. 4. The administrator is responsible for ensuring these goals are met. 5. 9/14/23	09/14/2023

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0965 SS= C	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (a) The facility ' s policies and procedures for providing care to its residents; Inspector Comments: Based on record review and interview, the facility Administrator failed to ensure the facility developed a policy addressing dangerous and toxic items in the memory care unit. Findings include: On 09/14/23 at approximately 3:15 PM, a policy addressing dangerous and toxic items was requested. On 09/14/23 at approximately 3:15 PM, the Administrator verbalized the facility did not have a policy addressing dangerous and toxic items in the memory care unit. The Administrator verbalized the corporate entity did not allow this policy to be developed; therefore, staff were verbally trainined on items the facility did not allow in the memory care unit. Severity: 1 Scope: 3	0965	1. A policy has been developed for dangerous and toxic items and it is attached. 2. All team members will be trained on the dangerous and toxic items policy. 3. Resident room audits will be completed weekly to ensure all dangerous and toxic items are removed and/or secured. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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0994 SS= D	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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure dangerous items were inaccessible to residents housed in the memory care unit for 1 of 12 occupied rooms (Room #3B). Findings include: On 09/14/23 at 09:05 AM, Room 3B had four AA batteries in the room. On 09/14/23 at 09:05 AM, the Director of Environmental Services confirmed the batteries could be dangerous to residents in the memory care unit and should be secured. The facility lacked a policy addressing dangerous items in the memory care unit. Severity: 2 Scope: 1	0994	1. All dangerous items were removed from Room #3B. 2. A sweep of all memory care resident apartments was completed and any dangerous or toxic items were removed. 3. An audit of memory care rooms will be completed weekly to ensure all rooms are free of dangerous and toxic items. Example of the audit form is attached. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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0999 SS= E	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 and interview, the facility failed to ensure toxic substances were inaccessible to residents housed in the memory care unit for 5 of 12 occupied rooms. Findings include: On 09/14/23, the following rooms in the memory care unit contained toxic items: - Room 1B - at 9:56 AM, a 3.4-ounce tube of Sensodyne toothpaste was in the nightstand drawer. - Room 3A - at 10:02 AM, a bar of dove soap was in the shower of the bathroom. - Room 3B - at 10:07 AM, a four-ounce container of Bath and Body Works Hand Repair was in the room. - Room 5B - at 10:16 AM, a plastic zippered bag with two bars of soap, a 2.7-ounce stick deodorant, and a 12-ounce container of Pantene conditioner were in the resident's room. On 09/14/23 at 9:56 AM through 10:16 AM, the Director of Environmental Services confirmed the presence of unsecured toxic substances. The facility lacked a policy addressing toxic items in the memory care unit. Severity: 2 Scope: 2	0999	1. All toxic items were removed or secured in all memory care resident rooms. 2. A sweep of all memory care resident apartments was completed and any dangerous or toxic items were removed and training completed with the wellness team. 3. An audit of memory care rooms will be completed weekly to ensure all rooms are free of dangerous and toxic items. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/24	10/17/2023

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1001 SS= D	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 12 sampled employees working at the facility less than one year received four hours of initial training to care for elderly and disabled residents within 60 days of hire (Employee #2 and #12). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as a Medication Aide with a hire date of 05/04/23. Employee #2's personnel file lacked documented evidence of four hours of initial caregiver training. Employee #12 Employee #12 was hired by the facility as Resident Aide with a start date of 03/29/23. Employee #12's personnel file lacked documented evidence of four hours of initial caregiver training. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	1001	1. Employee #2 is no longer with the company. Employee #12 completed 4hrs of dementia training and that is attached. 2. An audit of all team member training files was completed to ensure all employees are in compliance. 3. All new employees will complete required training within the first week of training. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023
1035 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	1035	1. Employee #3 and #12 completed two hours of dementia training and that is attached. 2. An audit of all team member training files was completed to ensure all employees are in compliance. 3. All new employees will complete required training within the first week of training. 4. The administrator is responsible for	10/17/2023

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	contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 2 of 15 sampled employees providing care to residents with dementia received two hours of dementia training within 40 hours of the employees' start date (Employee #3 and #12). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #3 Employee #3 was hired by the facility as Medication Aide with a hire date of 03/01/23. Employee #3's personnel file contained documented evidence of two hours of dementia training was completed by 05/17/23. Employee #12 Employee #12 was hired by the facility as Resident Aide with a start date of 03/29/23. Employee #12's personnel file lacked documented evidence of dementia training. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1		ensuring these goals are met. 5. 10/17/23	
1036 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	1036	1. Employee #2 is no longer with the company. Employee #12 completed all eight hours of required Dementia training and it is attached. 2. An audit of all team member training files was completed to ensure all employees are	10/17/2023

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	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: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 3 of 10 sampled employees providing care to residents with dementia, working at the facility for less than one year, received eight hours of dementia training within 90 days of the employees' start date (Employee #2 and #12). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Medication Aide with a start date of 05/04/23. Employee #2's personnel file contained four hours of dementia training within 90 days of employment. Employee #12 Employee #12 was hired by the facility as Resident Aide with a start date of 03/29/23. Employee #12's personnel file lacked documented evidence of dementia training. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1		in compliance. 3. All new employees will complete required training within the first week of training. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	
1037 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for	1037	1. Employee #4 completed three hours of dementia care training and it is attached. Employee #11 is no longer employed with	10/17/2023

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	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 record review and interview, the facility failed to ensure 2 of 2 employees providing care to residents with dementia completed the required minimum of an additional three hours of training in providing care to a resident with dementia by the hire anniversary date (Employee #4 and #11). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #4 Employee #4 was hired by the facility as Medication Aide with		the company. 2. An audit of all team member training files was completed to ensure all employees are in compliance. 3. The employee tracker will be reviewed monthly to ensure that all training requirements are met. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	

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	a start date of 06/09/22. Employee #4's personnel file lacked documented evidence of three hours of annual dementia training. Employee #11 Employee #11 was hired by the facility as Resident Aide with a start date of 10/02/17. Employee #11's personnel file lacked documented evidence of three hours of annual dementia training. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
1540 SS= D	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 3 of 14 sampled employees required to obtain cultural competency training (Employee #2, #3, and #15). Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the	1540	1. Employee #2, #3, and #15 have all completed cultural competency training, however outside of the 30 day window. 2. An audit has been completed to ensure that all employees have completed the cultural competency training. 3. During new hire orientation, each employee will be scheduled for the cultural comptency monthly training. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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	following information: Employee #2 Employee #2 was hired by the facility as Medication Aide with a hire date of 05/04/23. Employee #2's personnel file lacked a cultural competency training certificate. Employee #3 Employee #3 was hired by the facility as Medication Aide with a hire date of 03/01/23. Employee #3's personnel file lacked a cultural competency training certificate. Employee #15 Employee #15 was hired by the facility as Medication Aide with a hire date of 09/13/22. Employee #15's personnel file contained a cultural competency training certificate dated 01/27/23. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
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 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	1700	1. A standard placement form has been completed for Residents #2, #4, #5, #8, and #13 and all are attached. Resident #1 no longer lives at the community. 2. An audit has been completed to ensure that all residents have a current standard placement form. 3. A resident audit will be completed monthly to ensure all annual standard placement forms are completed. Prior to admission, all required documentation will be reviewed by the administrator prior to move in. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23	10/17/2023

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	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 interview and clinical record review, the Administrator failed to ensure standard placement determination were completed by a provider initially upon admission and annually thereafter for residents with a diagnosis of dementia, not residing in memory care for 6 of 10 residents (Resident #2, #4, #5, #8, #13, and #1). Findings include: Resident #2 Resident #2 was admitted to the facility on 08/21/23, with diagnosis including atrial fibrillation, hypertension, chronic hypoxemia, and hyperthyroidism. Resident #2's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed upon admission. On 09/14/23 at 10:45 AM, the Administrator confirmed a Standard Physician Assessment and Placement Determination had not been completed upon admission for Resident #2. Resident #4 Resident #4 was admitted to the facility on 02/28/23, with diagnosis including Parkinson's disease, dementia, and chronic pain. Resident #4's clinical			

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	7766	A. BUILDING _____ B. WING _____	09/14/2023

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

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	record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed upon admission. On 09/14/23 at 1:20 PM, the Administrator confirmed a Standard Physician Assessment and Placement Determination had not been completed upon admission for Resident #4. Resident #5 Resident #5 was admitted to the facility on 01/31/22, with a diagnosis of dementia. Resident #5's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed upon admission and annually thereafter. On 09/14/23 at 1:15 PM, the Wellness Director confirmed a Standard Physician Assessment and Placement Determination had not been completed upon admission and annually for Resident #5. Resident #8 Resident #8 was admitted to the facility on 10/15/20, with diagnoses including dementia, diabetes mellitus type II, chronic kidney disease, and left sided weakness. Resident #8's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination was completed annually in 2022 and 2023. On 09/14/23 at 1:14 PM, the Administrator confirmed a Standard Physician Assessment and Placement Determination was not completed annually for Resident #8 during 2022 and 2023. Resident #13 Resident #13 was admitted to the facility on 08/17/22, with diagnoses including Alzheimer's, Parkinson's disease, depression, hypertension, and anxiety. Resident #13's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination was not completed in 2022 and 2023. On 09/14/23 at 3:26 PM, the Administrator confirmed a Standard Physician Assessment and Placement Determination was not completed for Resident #13 during 2022 and 2023. Resident #1 Resident #1 was admitted to the facility on 07/31/23, with diagnoses including leukocytosis and failure to thrive. Resident #1's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed upon admission. On 09/14/23 at 4:43 PM, the			

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	Administrator confirmed a Standard Physician Assessment and Placement Determination had not been completed upon admission for Resident #1. Severity: 2 Scope: 2			
1830 SS= F	Infection Control Required Training Inspector Comments: Based on personnel file review and interview, the primary infection control staff lacked the required infection control training. Findings include: On 09/14/23 at 11:03 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 10/01/22. On 09/15/23, Employee #1's personnel file lacked the required infection control and prevention training required for the primary infection control staff. On 09/14/23 at 1:15 PM, the Administrator provided the Attestation of Compliance form, signed and dated 09/14/23, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3	1830	1. Infection control training has been completed by employee #1 and it is attached. 2. An audit was completed and the administrator and wellness director have completed the required training. 3. The infection control managers will stay in compliance by completing all necessary training. 4. The administrator is responsible for ensuring these goals are met. 5. 10/17/23.	10/17/2023