STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted at your facility on 06/16/22. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility received a grade of 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 facility is licensed for 72 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 41. Fifteen resident files were reviewed, and ten employee files were reviewed. The facility requirements of NRS 449.101 - Discrimination prohibited; development of nondiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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	0000		

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	investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:			
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 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	0074	Employee# 9 completed training on 5/26/21 and 6/11/22, Employee #11 completed training upon hire on 12/21/21 (training documents attached). The Business Office Director will audit training records upon hire and quarterly per the Quality Assurance -Business Office Review Schedule.	06/16/2022

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	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, 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,			

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	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 Administrator of the facility failed to ensure 2 of 10 sampled employees completed annual training to recognize and prevent abuse of older persons or initial training to recognize and prevent abuse of older persons before providing care to residents (Employee #9 and #11). Findings include: Employee #9 Employee #9 was hired on 10/15/19 as the Life Enrichment Director. Employee #9's record documented initial elder abuse prevention training was completed on 05/26/21 but lacked documented evidence annual elder abuse prevention training had been completed for 2022. Employee #11 Employee #11 was hired on 12/21/21 as a Caregiver. Employee #11's record lacked documented evidence initial elder abuse prevention training had been completed. On 06/16/22 at 2:06 PM, the Business Office Director confirmed Employee #9 had not yet completed annual elder abuse prevention training and should have been completed by 05/26/22. The Business Office Director confirmed Employee #11 had been providing care to residents since the employees hire date of 12/21/21, and Employee #11 had not yet completed initial elder abuse prevention training. Severity: 2 Scope: 1			

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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 employee record review and interview, the facility failed to ensure a tuberculosis (TB) screening was completed for 1 of 10 sampled employees (Employee #7), and pre-employment physicals examinations were completed for 3 of 10 sampled employees (Employee #7, #12 and #15). Findings include: Employee #7 Employee #7 was hired as a Registered Dietitian. The facility lacked an employee record for Employee #7 to include a completed TB screening and a completed pre-employment physical. Employee #12 Employee #12 was hired on 06/08/22 as a Medication Technician. Employee #12's record lacked documented evidence a pre-employment physical examination to include screening for communicable diseases was completed. Employee #15 Employee #15 was hired on 09/07/21 as a Caregiver. Employee #15's record lacked documented evidence a pre-employment physical examination to include screening for communicable diseases was completed. On 06/16/22 at 2:06 PM, the Business Office Director confirmed the facility did not have an employee record, a completed TB screening or a pre-employment physical examination for Employee #7. The Business Office Director confirmed Employee #12 and Employee #15 had been providing care to residents since each of the employees' hire dates of 06/08/22 and 09/07/21, respectively; and Employee #12 and Employee #15 had not completed a pre-employment physical examination. Severity: 2 Scope: 1	0102	Employee # 7(Registered Dietitian) is a contracted consultant. Employee #7 no longerprovides services to the facility as of 7/15/22 (see attached 30-day notice). Employee #12 has an additional appointment scheduled on 9/20/22 to confirm and documentthat the employee is free from active tuberculosis and any other communicabledisease. Employee #15is no longer employed with facility as of 7/8/22. The BusinessOffice Director will ensure that documentation of Pre-Employment Physical andcommunicable disease screening is received at time of employment and will beaudited quarterly per the Quality Assurance – Business Office Review Schedule.	06/16/2022

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0104 SS= D	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 ensure a Registered Dietitian (RD) met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125, and to be screened through the facility's established Internet website for 1 of 10 sampled employees (Employee #7). Findings include: Employee #7 Employee #7 was hired as a RD. The facility lacked an employee record for Employee #7 to include fingerprints, a Nevada Automated Background Check System (NABS) Clearance Letter, or a written criminal history statement. The facility's NABS account lacked documented Employee #7 had been entered using the facility's established Internet website. On 06/16/22 at 10:02 AM, the Wellness Director confirmed the facility did not have an employee record for Employee #7. The Wellness Director verbalized the Employee #7 was the RD and would come into the facility on occasion and work with the Dining Services Director. On 06/16/22 at 11:18 PM, the Executive Director confirmed the facility lacked an employee record for the RD (Employee #7) to include a background check determination and health screenings. The Executive Director verbalized the RD would come into the facility every quarter to review and sign off on resident menus. On 06/16/22 at 2:06 PM, the Business Office Director confirmed the facility did not have fingerprints, a NABS Clearance Letter or written criminal history statement for Employee #7 and had not been screened through the facility's established Internet website. Severity: 2 Scope: 1	0104	Employee # 7(Registered Dietitian) is a contracted consultant. Employee #7 no longerprovides services to the facility as of 7/15/22 (see attached 30-day notice). The BusinessOffice Director will ensure that documentation related to state backgroundcheck requirements are on file for employees and independent contractors andwill be audited quarterly per the Quality Assurance – Business Office ReviewSchedule.	06/16/2022

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0172 SS= D	Health And Sanitation-Garbage - NAC 449.209 Health and sanitation. (NRS 449.0302) 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. Inspector Comments: Based on observation and interview, the facility failed to ensure a garbage dumpster was covered. Findings include: On 06/16/22 at 10:18 AM, one garbage dumpster lid was propped open in the refuse area outside of the facility. On 06/16/22 at 10:20 AM, the Maintenance Director confirmed the dumpster lid was propped open. The Maintenance Director verbalized the lid should have been shut to prevent rodent and pest infestations. Severity: 2 Scope: 1	0172	Staff education and posted reminders are in place for staff to ensure that exterior dumpster lid remains closed (see attached photo of signage). The Maintenance Director or designee will audit quarterly and as needed per the Quality Assurance – Quarterly Building Inspection.	06/16/2022

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0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 06/17/22, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. During inspection, kitchen staff were observed washing their hands with gloves on in-between dishwashing duties. Kitchen staff were handling clean dish ware without properly washing their hands after handling soiled dish ware. 2. Major Violations: a. Potentially hazardous foods (mashed potatoes and ham) were not properly identified and dated in a reach-in refrigerator. Severity: 2 Scope: 2	0255	Dining Services Staff received additional training on removing gloves and proper handwashing when going from soiled to clean (see attached in-service log). Food that was not identified and dated was removed from the refrigerator. Dining Services staff received additional training on labeling and dating open food items. The Dining Services Director or designee will audit upon hire and weekly per the Quality Assurance - Dining Services Review Schedule.	06/16/2022

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0450 SS= D	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. Inspector Comments: Based on employee record review and interview, the facility failed to ensure 2 of 10 sampled employees received training and certification to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #1 and #15). Findings include: Employee #1 Employee #1 was hired on 04/11/22 as the Executive Director. Employee #1's record lacked documented evidence the employee was certified to perform CPR and first aid. Employee #15 Employee #15 was hired on 09/07/21 as a Caregiver. Employee #15's record lacked documented evidence the employee was certified to perform CPR and first aid. On 06/16/22 at 2:06 PM, the Business Office Director confirmed Employee #1 and #15 had not completed the training to be certified to perform CPR and first aid. Severity: 2 Scope: 1	0450	Employee# 1 completed first aid and cardiopulmonary resuscitation training on 03/23/2022,documentation was provided to survey team on-site prior to exit on 06/16/2022(see attached training records). Employee #15is no longer employed with facility as of 7/8/22. The Business Office Director or designee will audit uponhire and quarterly per the Quality Assurance - Business Office Review Schedule.	06/16/2022

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0451 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to maintain the contents of a first aid kit required by Nevada Administrative Code 449.231(2)(a-f). Findings include: On 06/16/22, a review of the facility's first aid kit located Cares Station included a bottle of wound cleanser with an expiration date of 01/2022. The kit lacked a germicide safe for humans and a shield or mask for use in administering cardiopulmonary resuscitation (CPR). On 06/16/22 at 12:01 PM, a Caregiver confirmed the wound cleanser in the first aid kit was expired and the kit lacked a CPR shield/mask and a germicide safe for humans. Severity: 2 Scope: 1	0451	The designated first aid kit has been updated to include all items listed within the rule. The Wellness Director or designee will audit quarterly and as needed for expiration dates or replacement items.	06/16/2022
0590 SS= G	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on observation and interview, the facility failed to protect a resident from abuse by an employee (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility on 03/11/20, with diagnoses including dementia, diffuse traumatic brain injury with loss of consciousness of unspecified duration, and other epilepsy and recurrent seizures. On 06/16/22 at	0590	Employee#4 was immediately removed from the schedule, assigned additional training:Alzheimer Disease and Related Disorders: Behavior and ADL Management &Essentials of Resident Rights and Elder Abuse training (Please see attached forcompletion). Employee is no longer employed at the community as of 09/20/2022. Employee #15is no longer employed with facility as of 7/8/22. TheWellness Director or designee will complete a Caregiver Skills Observation uponhire, annually and as needed per the Quality Assurance -	06/16/2022

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	11:58 AM, a Medication Technician (MT) approached Resident #16 while the resident was reclined in a recliner in the common area of the dining room. The MT abruptly pushed the foot rest on the recliner in, without speaking to the resident, causing the resident to startle. The residents arms flailed out in surprise. The MT attempted to pull the resident up from the chair by the resident's left arm. The resident pulled back and resisted the MT with a confused and scared look on the resident's face. The MT picked the resident up by placing both hands in each of the resident's armpits then roughly and forcefully transferred the resident into the resident's wheelchair by shoving the resident into the wheelchair. The MT wheeled the resident to a dining table and left. On 06/16/22 at 12:02 PM, a Caregiver verbalized Resident #16 was an easily scared resident. The Caregiver explained when approaching the resident to provide cares or transfers, the Caregiver would get on the resident's level and speak with the resident, so the resident understood what was happening prior to engaging the resident physically. The Caregiver verbalized the resident was fragile and had stiff legs and extra time must be taken to assist the resident. On 06/16/22 at 12:09 PM, Resident #16 was sitting in a wheelchair with their head down at a dining table. The resident was unable to verbally respond to the Surveyor, but looked up with a wide pleasant smile in response to the Surveyor saying the resident's name. On 06/16/22 at 12:21 PM, the Wellness Director verbalized Resident #16 was a one person assist and was not able to stand on their own. The Wellness Director explained the resident likes to be in a recliner. The resident tenses up when care was being provided. The staff speak to the resident prior to initiating care, move slowly when providing care and give a "loving touch". The Wellness Director confirmed Resident #16 startled easy and did not have combative behaviors. On 06/16/22 at 1:05 PM, the MT verbalized the MT cares for residents that are easily startled and would approach a resident from the front and speak to the resident prior to touching the resident to prevent startling the		Health Services ReviewSchedule.	

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	residents. The MT verbalized Resident #16 was skittish, non-combative, and scared easily. The MT confirmed the MT did not speak with Resident #16 prior to pushing in the resident's footrest on the recliner and the resident startled at the contact. The MT confirmed the MT pulled the resident by one arm to transfer the resident. The MT confirmed pulling the resident by one arm was not the proper way to transfer a resident. On 06/16/22 at 1:29 PM, the Executive Director (ED) confirmed the MT had completed abuse training. The ED verbalized the interaction between the MT and Resident #16 was inappropriate and not in line with abuse training. Severity: 3 Scope: 1			
0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to ensure the service rates were posted in a conspicuous place. Findings include: On 06/16/22 at 8:30 AM, during an initial tour of the facility, there was no evidence the service rates were posted in a conspicuous place. On 06/16/22 at 9:43 AM, the Executive Director confirmed the service rates were not posted at the current time. Severity: 1 Scope: 3	0644	Upon investigation, the posting had been removed the night before to clean from dust. Posting was placed back on the wall the morning of 6/16. The Executive Director or designee will audit monthly and as needed to ensure compliance with Posting Requirements. Document uploaded should have been for 0872.	06/16/2022

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	8994	A. BUILDING _____ B. WING _____	06/16/2022

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ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

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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 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 1 of 15 sampled residents received an intial physical examination prior to admission (Resident #5), and failed to ensure an annual physical was completed for 1 of 15 sampled residents (Resident #3). Findings include: Resident #5 Resident #5 was admitted on 01/03/22, with diagnoses to include vascular dementia, hypertension, hyperlipidemia, and congestive heart failure. Resident #5's file contained an initial physician examination dated 01/05/22, two days after the resident had been admitted to the facility. On 06/16/22 at 10:45 AM, the Wellness Director confirmed the resident had not had a physical examination prior to admission to the facility. Resident #3 Resident #3 was admitted to the facility on 08/31/17, with a diagnosis of dementia. Resident #3's file documented an annual physical dated 09/28/20 and lacked documented evidence of an annual physical examinatioin for 2021. On 06/16/22 at 10:55 AM, the Wellness Director confirmed Resident #3 had not received an annual physical examination for 2021. Severity: 2 Scope: 1	0859	Resident #5 was not able to have the initial physical evaluation completed until two days after admission, Resident #3 was not able to have the initial physical evaluation. The Wellness Director or designee will audit for initial and annual physical examinations upon move-in and quarterly per the RSL Assessment Tool.	06/16/2022
0870 SS= D	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	0870	ThePharmacist from the contracted pharmacy completes routine medication reviewsfor all residents routinely (visits are not greater than six months). When thepharmacist has a	06/16/2022

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	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 document review and interview, the Administrator failed to ensure a medication profile review was conducted by a physician, pharmacist, or registered nurse at least once every six months for 2 of 15 residents (Resident #9 and #15). Findings include: Resident #9 Resident #9 was admitted to the facility on 06/04/19, with diagnoses to include dementia. Resident #9's medical record contained a medication review dated 02/02/22. The facility was unable to provide documented evidence of a medication review completed prior to 02/02/22. Resident #15 Resident #15 was admitted to the facility on 07/29/21, with diagnoses to include dementia, hypothyroidism, hypertension, and depression. Resident #15's medical record contained a medication review dated 02/02/22. The facility was unable to provide documented evidence of a medication review completed prior to the 02/02/22 medication review. On 06/16/22 at 11:13 AM, the Wellness Director confirmed Resident #9's record and Resident #15's record did not contain documentation of a medication review completed prior to 02/02/22. Severity: 2 Scope: 1		recommendation, the primary care provider is faxed a physiciancommunication form that is completed and provided by the contracted pharmacy.Resident # 9 & Resident # 15 are attached. The Administratorwill review the recommendations from the pharmacist upon receipt, and ensurerecommendations are faxed to the provider for review and direction, then filedin the resident medical chart.	

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0872 SS= D	Medication Educ Initial/annual Administrator - 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: (f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training. (g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training. (h) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on employee record review and interview, the Administrator failed to maintain current medication management training. Findings include: The employee record for the Administrator with a start date of 04/11/22, lacked documented evidence of at least 16 hours of training in medication management. On 06/16/22 at 2:06 PM, the Business Office Director confirmed the Administrator had not completed medication management training. Severity: 2 Scope: 1	0872	The Administrator completed training on 4/5/22 and is valid until 4/5/23. A copy of the certification was provided to inspectors during the survey (see attached). The Business Office Director (or designee) will audit upon hire and quarterly per the Quality Assurance – Business Office Review Schedule.	06/16/2022
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions	0878	A change label was placed on the Morphine for Resident #5. The Med-Tech's received additional training on placing change labels on medications when new orders are received at the facility. The Wellness Director or	06/16/2022

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	of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure a change label was affixed to a medication for 1 of 15 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 01/03/22, with diagnoses to include vascular dementia, hypertension, hyperlipidemia, and congestive heart failure. Resident #5's June 2022 Medication Administration Record (MAR), and physician order dated 04/29/22, documented Morphine sulfate immediate release 20 milligram/milliliter. Take 0.5 milliliter (10 milligram) by mouth every hour as needed for pain or shortness of breath. The medication label documented Morphine sulfate 100 milligram/milliliter (20 milligram/milliliter). Take 0.25 milliliter by mouth every hour as needed for pain. On		designee will provide training on change stickers upon hire per the Med-Tech Training Checklist (Following Medication Administration Rights).	

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	06/16/22 at 2:25 PM, a Medication Technician verbalized the medication container lacked the required change label. Severity: 2 Scope: 1			

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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 2 of 15 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #14 and #12). Findings include: Resident #14 Resident #14 was admitted to the facility on 03/11/20, with a diagnosis of traumatic brain injury. Resident #14's file documented a TB test with a negative result on 01/21/21 and a two-step TB test administered on 05/10/22 and 05/20/22. On 06/16/22 at 1:20 PM, the Wellness Director confirmed Resident #14's annual TB test for 2022 was administered late and should have been completed by the end of January 2022. Resident #12 Resident #12 was admitted on 12/07/20, with diagnoses to include Alzheimer's disease and osteoporosis. Resident #12's file contained documentation of an initial Quantiferon test performed on 07/06/20. Resident #12's file contained documentation of a two-step TB test. The first step was administered on 05/10/22 and read on 05/13/22.The second step was administered on 05/20/22 and read on 05/23/22. Resident #12's record lacked documented evidence of an annual TB test performed in 2021. On 06/16/22 at 1:07 PM, the Wellness Director confirmed an annual TB test had not been performed in 2021. Severity: 2 Scope: 1	0936	During a chart audit the Wellness Director discovered TB was out of compliance for 2 residents. TB tests were obtained upon internal audit findings. The Wellness Director or designee will audit resident records upon admission and annually per the Quality Assurance – Clinical Services Review Schedule.	06/16/2022
0999	Alzheimer 's Care Standards for Safety -	0999		06/16/202

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SS= F	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 living in the secured unit. Findings include: On 06/16/22, during the initial tour of the facility, the following toxic substances were identified as unsecured: Room 56 A 2.7 ounce tube of fluoride toothpaste with an active ingredient of sodium monoflourophosphate was located in the bathroom of a resident residing in a secured unit. On 06/16/22 at 10:09 AM, a Medication Technician (MT) confirmed the toothpaste should not be accessible to the resident and should have been secured. The MT verbalized the unsecured substance may be dangerous to the resident if ingested. Dining Room/Activities Common Area Five hand sanitizer dispensers were located in the dining room /common area where residents eat, watch television, and participate in activities. The hand sanitizer dispensers were located at each exit and within reach of any resident. The Safety Data Sheet (SDS), revised 04/17/20, documented the active ingredient in the hand sanitizer was ethyl alcohol and should not be ingested. The SDS revealed the product causes serious eye irritation and is a flammable liquid and vapor. The SDS's first aid measures include: - Eye Contact: Rinse immediately with plenty of water, also under eyelids, for at least 15 minutes. Call a physician if irritation persists. - Skin Contact: If skin irritation occurs, rinse affected area with water. - Inhalation: Remove to fresh air. - Ingestion: Drink two to three large glasses of water. Do not induce vomiting. Call a physician. On 06/16/22 at 12:40 PM, the Maintenance Director confirmed the five hand sanitizer dispensers located in the dining room were easily accessible to residents and contained		The Tooth paste tube was immediately removed from the bathroom of apartment #56. The five hand sanitizer dispensers were removed (previously required to be placed forCovid-19 infection control compliance). The Wellness Director or designee will evaluate the resident for the ability to safely store grooming supplies in the resident apartment with each service plan update and as needed.	2

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	a substance toxic to the residents. The Maintenance Director verbalized the hand sanitizer could be a danger to the residents if ingested or came into contact with skin or eyes. On 06/16/22 at 1:21 PM, the Executive Director (ED) reviewed the SDS for the hand sanitizer and confirmed the hand sanitizer was toxic and accessible to residents in the dining/common area. The ED verbalized it was important to restrict access to the hand sanitizer so residents do not accidentally ingest the substance. Severity: 2 Scope: 3			
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 employee record review and interview, the facility failed to ensure 1 of 10 sampled employees received four hours of initial training to care for elderly and disabled residents within 60 days of hire (Employee #11). Findings include: Employee #11 Employee #11 was hired on 12/21/21 as a Caregiver. Employee #11's record lacked documented evidence initial training to care for elderly and disabled residents had been completed. On 06/16/22 at 2:06 PM, the Business Office Director confirmed Employee #11 had not completed training for the care of elderly and disabled residents. Severity: 2 Scope: 1	1001	Employee #11 completed 9 hours of initial training to care for the elderly within 60 day sof hire (see attached). The Business Office Director or designee will audit upon hire and quarterly per the Quality Assurance – Business Office Review Schedule.	06/16/2022

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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 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 employee record review and interview, the facility failed to ensure 1 of 10 sampled employees received two hours of Alzheimer's training within 40 hours of employment (Employee #12). Findings include: Employee #12 Employee #12 was hired on 06/08/22 as a Medication Technician. Employee #12's record lacked documented evidence two hours of Alzheimer's training was completed within 40 hours of employment. On 06/16/22 at 2:06 PM, the Business Office Director confirmed Employee #12 did not complete any Alzheimer's training within the first 40 hours of employment. Severity: 2 Scope: 1	1035	Employee #12 did not complete the assigned training within first 40 hours of employment. Employeecompleted the two hours of specific training on 06/19/2022. Employee # 11 hadorientation on 6/8, worked on 06/12 & 06/13. Her next schedule day was 06/196 2 p – 10:30p. Employee completed training within 40hours (please see attached). The BusinessOffice Director or designee will audit upon hire and quarterly per the QualityAssurance – Business Office Review Schedule.	06/16/2022

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1100 SS= F	Weights - Training/Consent - Approved Regulation - LCB File# R109-18 (13) (4) 4. A caregiver may weigh a resident of a residential facility only if: (a) The caregiver has received training on the manner in which to weigh a person that meets the requirements of subsections 5 and 6; and (b) The resident has consented to being weighed by the caregiver. Inspector Comments: Based on document review and interview, the facility failed to provide protocols, training and competency assessments for 19 Caregivers and nine Medication Technicians performing monthly resident weight measurements to all current facility census residents. Findings include: On 06/16/22 at 10:02 AM, the Wellness Director verbalized residents' had their weight measured every month and any Caregiver or Medication Technician could perform the weight measurement. On 06/16/22 at 1:11 PM, the Executive Director verbalized the facility was taking monthly weight measurements of all residents. The Executive Director confirmed none of the employees preforming weight measurements had been trained to do so. On 06/16/22 at 2:06 PM, the Business Office Director confirmed the facility currently had 19 Caregivers and nine Medication Technicians performing monthly weight measurements on residents and confirmed none of the Caregivers or Medication Technicians had completed weight measurement training. The facility policy titled, "Vital Signs and Weights Monthly Flowsheet," revised 12/28/15, documented residents were to have their weight measured monthly. The facility policy lacked language of the requirement for training to perform weight measurements. Severity: 2 Scope: 3	1100	Trainingprovided by a licensed nurse is scheduled to be completed on 9/29/22. The Administrator will ensure training iscompleted by a physician, physician assistant, or licensed nurse	06/16/2022