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 _____	03/27/2024

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 03/27/2024. 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 is licensed for 72 Residential Facility for Group beds for elderly or disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 49. Fifteen resident files were reviewed, and ten employee files were reviewed. The facility received a grade of B. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	0000		
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	0074	Employee #4 completed the Elder Abuse Training on3/15/24. Employee #5 completed the Elder Abuse Training on 1/23/24. All otheremployees completed the Elder Abuse Training per rule. The Business Office Director will schedule Elder AbuseTraining to be completed prior to the employee providing care for a resident inthe facility. The Business Office Director will audit and maintainthe staff records checklist monthly per the Quality Assurance Review Schedule.	04/19/2024

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 _____	03/27/2024

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
	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, 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		The Executive Director will be responsible forensuring that compliance is maintained.	

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 _____	03/27/2024

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
	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 facility failed to ensure 2 of 10 sampled employees received initial elder abuse prevention training prior to starting to work with residents (Employee #4 and #5). Findings include: On 03/27/2024 at 9:32 AM, the Business Services Office Director (BOD) was provided with the Personnel Check List to complete for 10 sampled employees. On 03/27/2024, the BOD provided the completed form with the following information: Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 03/07/2024. Employee #4's personnel file documented an elder abuse prevention training dated 03/15/2024, 8 days after starting work with residents. Employee #5 Employee #5 was hired by the facility as a Caregiver with a start date of 01/16/2024. Employee #5's personnel file			

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 _____	03/27/2024

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
	documented an elder abuse prevention training dated 01/23/2024, 7 days after starting work with residents. On 03/27/2024 at 12:41 PM, the BOD confirmed the findings Employee #4 and #5 did not complete elder abuse prevention training prior to starting to work with residents. Severity: 2 Scope: 1			

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 _____	03/27/2024

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
0255 SS= F	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 3/27/2024, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. A rodent infestation was observed during inspection. The observed areas with rodent activity were the kitchen dry storage room and laundry services. 2. Major Violations: a. Exposed and uncovered desserts were observed in an under-counter refrigerator in the front serving area. b. The kitchen, dishwashing area, and dry storage room floors, walls, food equipment, counter-tops, were heavily soiled with food debris during inspection. c. Chafing dish sterno was not properly stored. The sterno was observed stored unorganized and leaking sterno in a box near the back of the kitchen area. 3. Equipment and Maintenance Violations: a. The laundry area outside of the kitchen was not maintained in good condition during inspection. The floors and walls underneath and behind laundry equipment were damaged and dirty with lint. This also included the laundry equipment and dryer ducting. In addition, a rodent infestation was observed behind the laundry equipment. b. The cook's line service station equipment was in disrepair at the time of inspection. Further observation revealed the under-counter refrigerator was left on and had been soiled with food debris. Staff interview revealed the refrigerator was not in use but left on. The temperature of the refrigerator was over 90 degrees F. Severity: 2 Scope: 3	0255	The contracted pest company has completed a site visit to remedy any rodent infestation in the facility. Flooring was completed on 4/18/2024 (see pictures attached). The kitchen, dishwashing area, and dry storage room have all received a deep cleaning. The under-counter refrigerator has been disabled, cleaned, and is out of service. The dining services staff will receive additional training on the cleaning schedule and food storage (covering, labeling, anddating) on 4/18/24. The Dining Services Director will complete the Storage and Sanitation Audit weekly per the Quality Assurance Review Schedule.Documentation of audit and findings will be provided to the Executive Director for review and filing. The Executive Director will be responsible for ensuring that compliance is maintained.	04/19/2024
0874 SS= F	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours	0874	The Facility received the report from the outside Pharmacist Consultant on Thursday	04/19/2024

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 _____	03/27/2024

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
	after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review, document review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, was reviewed and initialed by the Administrator within 72 hours for 6 of 15 residents residing in the facility for longer than six months (Resident #2, #3, #4, #9, #13 and #15), and inform a resident's provider of a recommendation resulting from a six month medication profile review within 72 hours for 3 of 15 residents (Resident #2, #15, and #3). Findings include: Administrator's Initial The following residents residing in the facility longer than six months lacked the Administrator's initials within 72 hours for a six month medication profile review conducted on 01/30/2024 and received 02/01/2024 and not reviewed until 02/05/24: - Resident #2 was admitted to the facility on 09/25/2023, with diagnoses including memory loss, hypothyroidism, depression, and major depressive disorder. - Resident #3 was admitted to the faciity on 01/17/2022, with diagnoses including dementia and hypertension. - Resident #4 was admitted to the facility on 07/14/2022, with diagnoses including dementia with behavioral disturbances, hypertension and insomnia. - Resident #9 was admitted to the facility on 06/22/2023, with diagnoses including dementia, heart failure and cerebral atherosclerosis. - Resident #13 was admitted to the facility on 05/25/2023, with diagnoses including Alzheimer's disease and hypertension. - Resident #15 was admitted to the facility on 02/11/2021, with a diagnosis of vascular dementia with behavioral disturbances. Resident Provider Notification The following residents' providers were not notified of a		February 1, 2024. The report was reviewed and initialed by the Executive Director on Monday February 5, 2024. The providers were notified of the Pharmacist's recommendations outside of the 72 hours. The Wellness Director will fax any recommendations to the provider upon receipt of the outside Pharmacist Consultant report. The Executive Director will review and initial within 72 hours of receipt, then file the completed record with the Quality Assurance Records. The Executive Director will be responsible for ensuring that compliance is maintained.	

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 _____	03/27/2024

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
	recommendation from a six month medication profile review conducted on 01/30/2024: - Resident #2 was admitted to the facility on 09/25/2023, with diagnoses including memory loss, hypothyroidism, depression, and major depressive disorder. - Resident #15 was admitted to the facility on 02/11/2021 with a diagnosis of vascular dementia with behavioral disturbances. The following residents' provider was not notified of a recommendation from a six month medication profile review conducted on 04/27/2023: - Resident #3 was admitted to the facility on 01/17/2022, with diagnoses including dementia and hypertension. On 03/27/2024 at 9:55 AM, the Wellness Director confirmed the late signature by the Administrator on the medication profile review conducted on 01/30/2024, the missing provider and Administrator signatures on the medication recommendation provided from the medication profile review on 01/30/2024 and 04/27/2023, and verified the residents' providers had not been notified of the Pharmacist's recommendations within 72 hours. Severity: 2 Scope: 3			
1700 SS= D	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	1700	Resident #14 moved into the facility on 4/5/19. The provider completed the initial Physician Placement Determination, however, did not write the date next to signature. The Wellness Director will verify that the provider has signed and dated each Physician Placement Determination form prior to filing in the Resident Medical Chart. The Executive Director will be responsible for ensuring that compliance is maintained.	04/19/2024

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 _____	03/27/2024

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
	examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to obtain an initial Physician Placement Determination for 1 of 15 residents (Resident #14). Findings include: Resident #14 was admitted to the facility on 04/05/19, with diagnoses including dementia and heart failure. Resident #14's record included a Physician Placement Determination Statement which contained the resident's name and a determination, but was not dated by the provider. On 03/27/2024 at 11:01 AM, the Wellness Director confirmed the facility lacked documented evidence an initial Physician Placement Determination had been completed for Resident #14. Severity: 2 Scope: 1			

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 _____	03/27/2024

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
1830 SS= D	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on personnel file review, document review, and interview, the infection control designee lacked the required infection control training potentially affecting 49 of 49 residents. Findings include: On 03/27/2024 at 2:00 PM, the personnel file for the Maintenance Director, the infection control designee, lacked documented evidence of 15 hours of training concerning the control and prevention of infectious disease from the approved nationally recognized organizations. The Administrator confirmed the required infection control and prevention training had not been completed by the Maintenance Director. Severity: 2 Scope: 1	1830	The Infection Control designee has completed 15 hours of training concerning the control and prevention of infectious disease. The Infection control designee will then complete 15 hours of training annually. The Business Office Director will audit and maintain the staff records checklist monthly per the Quality Assurance Review Schedule. The Executive Director will be responsible for ensuring that compliance is maintained.	04/19/2024