DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/03/2024**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 07/03/2024 and conlcuded on 06/17/2024 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 48. Six resident files were reviewed, and four employee files were reviewed. There were three complaints investigated. Complaint #NV00071270 and Complaint #NV00071340 with the allegation of another resident's medication was administered to another resident was substantiated (See Tag Y0878). A deficiency unrelated to the allegations was identified (See Tag Y0895). Complaint #NV00071537 with the allegations the facility failed to prevent a resident from experiencing mental and physcial abuse, was substantiated (See Tag Y0590). 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		
0590 SS= E	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 interview, clinical record review and document review, the Administrator failed to ensure a resident	0590	Business Office Director to oversee Elder Abuse Training. Executive Director to audit through QA process. Executive Director and Wellness Director to investigate any reports of Abuse and Neglect. Employee will be suspended upon conducting investigation and terminated immediately if substantiated. Two Employees were terminated on 3/5/24 and 3/6/24.	03/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AMANDA JENKINS Title: Executive Director Date: 08/23/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	was safe from mental and physical abuse for 1 of 4 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 11/24/2021, with diagnoses including dementia, and hypertension. On 07/03/2024 at 10:52 AM, a Medication Technician (Med Tech) verbalized a resident was being mentally and physically abused by two Caregivers within the facility. The Med Tech had verbalized being told by both Caregivers, water and soda had been poured on the resident while sleeping, and the lights in Resident #7's room were intentionally turned on in the middle of the night multiple times in order to "taunt" the resident. On 07/03/2024 at 11:28 AM, the Wellness Director verbalized Resident #7 was uncomfortable with male Caregivers, and did not like the lights turned on at night. Upon an internal investigation, all allegations were substantiated. It was reported two Caregivers were intentionally mentally and physically abusing Resident #7, and both employees were terminated on 03/06/2024. An " Employee Counseling Form " dated 03/06/2024 stated that (Employee Name1) had participated in resident abuse and was submitted for suspension. The form stated, " (Employee Name1), it has been reported to management that you have been pouring water on residents, leaving lights on at night knowing residents do not like lights on, and forcing them to go to bed early. These accusations are violations of resident rights. These acts are considered Abuse of the residents. You are being suspended until all investigations are complete. If found substantiated, you will be terminated and reported to the state. " Also signed by (Supervisor). Witness Statement Form dated 03/06/2024 at 11:15 AM, stated as follows, "At some point in early-mid February, Caregiver (Employee Name2) reported to me that on several occasions Caregiver (Employee Name1) has come into room 30 with (Employee Name2) while			

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	(Employee Name1) put 30A to bed. Resident 30A does not like men in (Resident #7's) room, and (Employee Name2) is aware. (Employee Name1) also told me that (Employee Name2) purpose of being in there was to "mess with (Resident #7), and torture (Resident #7)." but (Employee Name1) was not more specific in what (Employee Name2) did, except for one occasion when (Employee Name1) told me (Employee Name2) poured water on (Resident #7) in (Resident #7's) bed. (Employee Name1) also told me that when (Employee Name2) was working and (Employee Name1) was assigned to room 30, (Employee Name1) would find the lights on in the room after 30A was in bed and sleeping. (Employee Name1) did not have the lights on because 30A is very vocal about not being able to sleep with any lights on. So (Employee Name1) suspected that throughout the evening (Employee Name2) was turning on room 30's lights to mess with her. I told (Employee Name1) to report this to the shift supervisor, but (Employee Name1) was afraid of retaliation. I did not witness any of these events firsthand." Witness Statement Form dated 03/06/2024 at 2:58 PM, stated as follows, "A few weeks ago I went to room 30A to give cream to 30A when entering 30A's room, I saw orange stuff all over (Resident #7's) night gown. I looked over to the right to the night stand and saw an empty cup of orange soda. I asked (Employee Name2) what happened and (Employee Name2) told me (Employee Name2) threw orange soda at the resident for throwing water at (Employee Name2) first. I then looked up and had to walk away. I went to the Med Tech to vent about what had just happened to (Resident #7). When walking to do perimeter checks at night, I've seen Caregiver (Employee Name1) walk to room 30A and just turn on the lights in the room and walk away. I've also seen (Employee Name1) walk into room 30A with (Employee Name2) many times. Maybe like three times			

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	total. I have also seen (Employee Name2) blow dry 30A's hair even with knowing that 30A likes her hair dry." Complaint #NV00070808 Severity: 2 Scope: 1			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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 , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. 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, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse 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 (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, physician assistant or advanced practice	0878	Resident #6 - Oxycodone order- Physician wrote a Discharge order and medication was destroyed. Resident #5 no longer resides in community. Wellness Director to Audit Medication Carts weekly. Executive Director to monitor through QA process.	06/13/2024

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	registered nurse 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, physician assistant or advanced practice registered nurse, a 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 record review, observation and interview, the facility failed to ensure 1) medications were onsite to administer the prescribed dosage for 1 of 6 sampled residents (Resident #6), 2) a change order sticker was affixed to the medication when a physician changed the order for 1 of 6 sampled residents (Resident #6), and 3) a medication was administered to a resident with a current physician order for 1 of 6 sampled residents (Resident #5). Findings include: Resident #6 Resident #6 was admitted to the facility on 02/23/2024, with diagnoses including dementia, acute renal failure and atrial fibrillation. On 06/13/2024 at 11:54 AM, during a review of the resident's medications, one medication was not onsite and one medication did not have a change order sticker. -Acetaminophen 325 milligram (mg) tablet, take two tablets by mouth every four hours as needed for headache, joint or muscle pain or fever more than 100 degrees, was not onsite -Oxycodone 5 mg tablet, take one tablet by mouth every six hours as needed for moderate pain for 14 days, lacked a change order sticker. Resident #6's June 2024 Medication Administration Record (MAR) and a physician's order dated 02/23/2024, documented the following. -Acetaminophen 325 milligram (mg) tablet, take two tablets by mouth every four hours as needed for headache, joint or muscle pain or fever more than 100			

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	degrees. Resident #6's June 2024 Medication Administration Record (MAR) and a physician's order dated 06/13/2024, documented the following. -Oxycodone 5 mg tablet, take one tablet by mouth every six hours as needed for severe pain up to three days. On 06/13/2024 at 12:05 PM, the Wellness Coordinator/Medication Technician confirmed the Acetaminophen was not onsite and a change order sticker was not affixed to the Oxycodone tablets. Resident #5 Resident #5 was admitted to the facility on 06/16/2022, with diagnoses including vascular dementia with behavior disturbance, hypertension, and chronic pain. Resident #1 Resident #1 was admitted to the facility on 04/05/2019, with diagnoses including unspecified dementia, atrial fibrillation and heart failure. On 04/17/2024 at approximately 1:30 PM, Resident #5 was administered Resident #1's Propafenone Hydrochloride (HCl) 150 mg tablet. A Progress Note dated 04/17/2024 at 1:34 PM, documented having gave Resident #1's 2:00 PM medication to Resident #5. Notified the Wellness Director and continued to monitor Resident #5. An incident report dated 04/17/2024, documented the Medication Technician gave Resident #1's 2:00 PM medication to Resident #5. The Wellness Director notified Resident #5's emergency contact/guardian, physician, and the Executive Director. Resident #5's physician's office instructed facility staff to monitor blood pressure and notify Emergency Medical Services of low blood pressure. On 06/13/2024 at 12:08 PM, the Wellness Coordinator explained the process to ensure medications were given correctly were using the six rights of medication administration, right patient, right medication, right dose, right time right route and right documentation. The Wellness Coordinator verbalized utilizing three checks prior to administering medication to the resident. The three checks consisted of check patient, check MAR, check medication. The Wellness Coordinator was			

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	not working at the facility at the time of the incident. On 06/13/2024 at 12:13 PM, the Medication Technician confirmed giving Resident #5 medication which was not prescribed to the resident. The Medication Technician explained not following the six rights of medication administration and did not complete three checks prior to administering the medication to Resident #5. The Medication Technician verbalized notifying the Wellness Director immediately once identifying giving a Propafenone HCl to Resident #5 who did not have a physician's order for Propafenone HCl. The facility policy titled "Treatment Management Medication" last revised 04/01/2020, documented prescription medication and treatment must be authorized for staff assistance by the resident's physician. Complaint #NV00071270 Complaint #NV00071340 Severity: 2 Scope: 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the	0895	Wellness Director to oversee and monitor Mar for compliance. Executive Director to monitor through QA process. Resident 1 no longer resides in community.	06/13/2024

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	medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on observation, interview, document review, and clinical record review, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/05/2019, with diagnoses including unspecified dementia, atrial fibrillation, and heart failure. A physician's order dated 10/16/2023, documented Nystatin 100,000 units per gram of cream. Apply to perineal area topically two times daily. The April 2024 MAR for Resident #1 lacked documented evidence the Nystatin was administered on 04/18/2024 at 6:00 AM. On 06/13/2024 at 12:59 PM, a Medication Technician explained the dash on the MAR may indicated the medication was not administered, or it was administered and not documented. The Medication Technician was unsure whether the medication was or was not administered. The facility policy titled "Medication/Treatment Management," undated, documented all medication administration assistance will be recorded by community staff on an appropriate resident electronic MAR. Severity: 1 Scope: 1			