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 _____	**12/27/2024**

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 State Licensure complaint investigation conducted at your facility on 12/27/2024, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 45. The Sample size was seven. There was one complaint investigated. Complaint #NV00072863 with an allegation ordered medications were not administered to residents was substantiated (See Tag Y878). The following allegations could not be substantiated due to a lack of evidence. -Allegation #2: Residents were not changed and left in wet clothing and wet beds for extended periods of time. -Allegation #3: Residents were not fed. The investigation into the allegations included: Observations of staff to resident interactions, resident hygiene/grooming, residents in day clothes, housekeeping in resident rooms, meals, and medication administration. Interviews with two residents, two medication technicians, the pharmacy, and the Executive Director. Review of five resident files, included review of diagnoses, service plans, ultimate user agreements, medication administration records (MARs), physician orders, activities of daily living (ADL) assessments, and physician communication forms. Review of facility documents including the Shower Schedule and Pharmacy Services Provider Agreement, Review of the facility policy including Perineal Care for Incontinent Residents, Infection Control: Soiled Laundry and Equipment, Meal Times, Snack List, Controlled Substances, Disposition of Medications, Medication Refills, and Medication and Treatment Management. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AMANDA JENKINS Title: Executive Director Date: 02/12/2025

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	available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0871 SS= D	Medication Administration - Plan - NAC 449.2742 and R043-22 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: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician, physician assistant or advanced practice registered nurse or other physician, physician assistant or advanced practice registered nurseof the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access	0871	Resident #1 no longer resides in community. All Medication Technicians attended a 1 hour Medication Management Training. Wellness Director to Audit Medication carts weekly. Executive Director to monitor through QA process.	12/28/2024

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	to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on interview, clinical record review, and document review, the facility's administrator failed to ensure staff followed facility policy for refilling medications when two scheduled physician ordered medications were not refilled timely to avoid missed dosages for 1 of 7 sampled residents (Resident #1). Findings include: Resident #1 was admitted to the facility on 12/13/2023 with a primary diagnosis of dementia without behavioral disturbance. Resident #1's December 2024 Medication Administration Record (MAR) documented the following: -Divalproex Sprinkles 125 milligram (mg) capsules. Take one capsule by mouth at bedtime for dementia. 12/13/2024 documented drug not given (DNG) and 12/15/2024 documented drug not available (DNA). -Pravastatin 10 mg tablet. Take one tablet by mouth every evening. 12/20/2024 and 12/21/2024 documented DNG, and 12/22/2024 documented DNA. Resident #1's progress notes documented the following: -On 12/13/2024, the resident missed their 8:00 PM Divalproex Sprinkles 125 mg capsules. -On 12/20/2024, the resident missed their 8:00 PM Pravastatin 10 mg tablet. The Physician was faxed, waiting on delivery. Resident #1's clinical record lacked documented evidence the Divalproex Sprinkles and Pravastatin was ordered when five to seven days of medication supply remained and follow up with the			

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	pharmacy occurred when a two-day supply remained. On 12/27/2024 at 2:00 PM, the Medication Technician verbalized Divalproex Sprinkles were not administered on 12/13/2024, and Pravastatin was not administered from 12/20/2024 to 12/22/2024 because the facility did not have the medications onsite. The Medication Technician verbalized when the medication packs were found to be empty, the order refill was requested from the pharmacy. The Medication Technician confirmed the Medication Technician did not order the Divalproex Sprinkles nor the Pravastatin when five-to-seven days of medication supply remained, and did not follow up with the pharmacy nor document in progress notes when a two-day supply of Resident #1's medications remained. On 12/27/2024 at 2:00 PM the Executive Director verbalized medication technicians were expected to request a medication refill when there was a seven-day supply remaining. The Executive Director explained medication technicians were then expected to follow up with the pharmacy and document in progress notes when there was a two-day supply remaining per facility policy. The Executive Director confirmed Resident #1's clinical record lacked documented evidence refills were requested for either medication when there was a seven- and two-day supply remaining. After a call with the pharmacy, the Executive Director confirmed Resident #1's Divalproex Sprinkles refill was requested on 12/13/2024 and delivered on 12/16/2024. The Executive Director confirmed Resident #1's Pravastatin refill was requested on 12/20/2024 and delivered on 12/23/2024. The Executive Director verbalized the facility did not have the Divalproex Sprinkles for three days from 12/13/2024 to 12/15/2024, nor the Pravastatin for three days from 12/20/2024 to 12/22/2024. and confirmed both medications were not administered for three days per the resident's MAR. The facility			

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	policy titled "Medication Refills," undated, documented medication technicians were responsible for ordering medications from the pharmacy. All refills should be ordered when there was a five-to-seven-day supply remaining and follow up with the pharmacy along with documentation in progress notes was expected when there was a two-day supply of a medication remaining. 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	0878	Resident #1 no longer resides in community. All Medication Technicians attended a 1 hour Medication Management Training. Wellness Director to Audit Medication carts weekly. Executive Director to monitor through QA process.	12/28/2024

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	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 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 interview, clinical record review, and document review, the facility failed to ensure two scheduled medications were administered per physician orders for 1 of 7 sampled residents (Resident #1). Findings include: Resident #1 was admitted to the facility on 12/13/2023 with a primary diagnosis of dementia without behavioral disturbance. Resident #1's December 2024 Medication Administration Record (MAR) documented the following: -Divalproex Sprinkles 125 milligram (mg) capsules. Take one capsule by mouth at bedtime for dementia. 12/13/2024 documented drug not given (DNG) and 12/15/2024 documented drug not available (DNA). -Pravastatin 10 mg tablet. Take one tablet by mouth every evening. 12/20/2024 and 12/21/2024 documented DNG, and 12/22/2024 documented DNA. Resident #1's progress notes documented the following: -On 12/13/2024, the resident missed their 8PM Divalproex Sprinkles 125 mg capsules. -On 12/20/2024, the resident missed their 8PM Pravastatin 10 mg tablet. The Physician was faxed, waiting on delivery. On 12/27/2024 at 2:00 PM, the Medication			

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	Technician verbalized Divalproex Sprinkles were not administered on 12/13/2024, and Pravastatin was not administered from 12/20/2024 to 12/22/2024 because the facility did not have the medications onsite. On 12/27/2024 at 2:00 PM, the Executive Director verbalized the facility did not have the Divalproex Sprinkles for three days from 12/13/2024 to 12/15/2024, nor the Pravastatin for three days from 12/20/2024 to 12/22/2024 and confirmed both medications were not administered for three days per the resident's MAR. Severity: 2 Scope: 1 Complaint #NV00072863			