STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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 State Licensure annual grading survey conducted at your facility on 09/11/2024. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for a total of 150 Residential Facility for Group beds: 126 beds for elderly and disabled persons and/or assisted living services, Category II residents and 24 beds for persons with Alzheimer's disease, Category II Alzheimer's residents. The census at the time of the survey was 106. Twenty-five resident files were reviewed and ten employee files were reviewed. The facility received a grade of D. Your facility has received a C or D grade for this inspection. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The	0920	1) Resident #101, 116, 202, and 21, have secured lock boxes. 2) All apartments in Assisted Living will have a lock installed on cabinet or drawer to secured items in. All self admin residents will have a secured space to store medications.	09/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 3 of 41 resident rooms with self-administering residents (Room #101, #116, and #202) and for 1 of 25 residents (Resident #21) Findings include: On 09/11/2024, the following resident rooms contained unsecured medications: Room 101 - at 10:37 AM, the resident was out of the room, medications were on the kitchen counter, and the room was unlocked. Room 116 - at 11:44 AM, the resident verbalized medications were not locked in the room and the door was not always locked when out of the room. Room 202 - at 11:24, the resident verbalized medications were not locked in the room and the door was not always locked when out of the room. On 12/06/23 at 11:24 AM through 11:44 AM, the Resident Care Coordinator confirmed the medications were not secured and verbalized all medications should be secured. Resident #21 Resident #21 was admitted to the facility on 08/03/2023, with diagnoses including aortic stenosis and hypertension. Resident #21's Ultimate User Agreement completed on 08/01/2023, documented the resident would self administer medications and the resident did not designate the facility staff to possess, administer, and monitor their medications. All medications would be kept in a locked		3) Residents and responsible parties will be notified of policy upon move in and room checks will be implemented to ensure all items are secured. 4) Health and Wellness Director, Resident Care Coordinator or designee will monitor for compliance. 5) 12/7/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	drawer or storage within the apartment. On 09/11/2024 at 1:26 PM, Resident #21 was in their apartment they share with their spouse. Two seven-day pill organizer containers were located on the table with pills in them. On 09/11/2024 at 1:27 PM, Resident #21 verbalized they self administer their own medications and keeps them on the table in the pill organizers. The resident verbalized the resident has a container to lock up their medications, but does not use it. On 09/11/2024 at 1:30 PM, the Wellness Director verbalized Resident #21 resided in the apartment with their spouse and Resident #21 was able to self administer their medications. The Wellness Director verbalized Resident #21's spouse was not capable of administering their medications and should not have access to Resident #21's medications. The Wellness Director confirmed Resident #21's medications were not secured from Resident #21's spouse. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
0994 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure dangerous items were secured in 1 of 21 resident rooms accessible to residents (Room #2). Findings include: On 09/11/2024 at 9:16 AM, five AAA, six AA, and two D batteries were stored in a drawer. On 09/11/2024 at 9:16 AM, the Maintenance Director confirmed the batteries were listed in the policy as items required to be secured. Facility policy, "Storage of Personal Care Items in Connections," updated 02/23, documented a list of items required to be secured when not in use including "Hearing Aides and Batteries." Severity: 2 Scope: 1	0994	1) Batteries were removed from apartment day of survey (9/11/2024), and secured. 2) Responsible parties and residents (if applicable) will be informed of policy upon move in and as necessary. Rooms will be monitored for compliance. 3) Memory Care Director or designee will monitor for compliance daily. 4) Memory Care Director or designee. 5) 9/11/2024	09/11/2024
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	1700	1. Res #2 - Standard placement form for AL updated effective 9/13/2024; Res #20 - Physician marked/updated secured environment determination on original form 9/18/2024; Res # 5 and #24 original Evaluation for Placement determined secured environment needed; Resident #8 - Standard placement form for AL obtained for 2024. 2. Standard placement for for AL will be obtained upon move in, change of condition and annually. Secured Environment Evaluation form will be obtained upon move in or upon change of condition that results in move to memory care. 3. Health and Wellness Director, Resident Care Coordinator or designee will ensure completed placement forms are obtained upon move in, change of condition and	09/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the 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 clinical record review and interview, the Administrator failed to obtain timely and complete annual Standard Physician Assessment and Placement Determinations and upon a significant change of cognition for 6 of 25 sampled residents with a diagnosis of dementia (Resident #25, #3, #2, #5, #8, #20, and #24). Findings include: Resident #25 Resident #25 was admitted to the facility on 03/17/2023, with a diagnosis of mild cognitive impairment, dementia and depression. Resident #25's clinical record documented a Standard Placement Determination completed on 02/22/2023, and the annual Standard Placement		annually. 4. Executive Director or Health and Wellness Director 5. 9/18/2024 6. Attachment A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	Determination completed on 05/20/2024, three months late. On 09/11/2024 at 11:22 AM, the Health and Wellness Director confirmed Resident #25's annual Standard Placement Determination was three months late and verbalized the facility was completing Standard Placement Determinations for all resident's in the facility upon admission and annually thereafter, regardless of diagnoses. Resident #3 Resident #3 was admitted to the facility on 12/01/2022, with a diagnosis of acute respiratory failure with hypoxemia. Resident #3 had a new diagnosis of dementia on 05/09/2023 Resident #3's clinical record documented a Standard Placement Determination completed on 08/21/2024, three months after Resident #3 had a new diagnosis of dementia. On 09/11/2024 at 11:41 AM, the Health and Wellness Director confirmed Resident #3 should have had a new Standard Placement Determination when the resident had a new cognitive impairment discovered. Resident #2 Resident #2 was admitted to the facility on 06/29/2020, with diagnoses including dementia and hypertension. Resident #2's clinical record included a Standard Placement Determination dated 07/06/2022. The clinical record lacked an annual Standard Placement Determination for 2024. On 09/11/2024 at 3:47 PM, the Health and Wellness Director confirmed Resident #2 did not have an annual Standard Placement Determination completed in 2024. Resident #5 Resident #5 was admitted to the facility on 05/09/2019, with a diagnosis of dementia. Resident #5's clinical record documented a Standard Placement Determination. dated 01/20/2023, but lacked an annual Standard Placement Determination completed in 2024. Resident #8 Resident #8 was admitted to the facility on 02/05/2021, with a diagnosis of dementia. Resident #8's clinical record documented a Standard Placement Determination dated 07/21/2022, but lacked an annual Standard Placement Determination completed in 2024. Resident #20 Resident #20 was admitted to the facility on 08/08/2024, with a diagnosis of dementia. Resident #20's Standard Placement Determination document dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	08/07/2024, lacked a placement determination. Resident #24 Resident #24 was admitted to the facility on 03/07/2023, with a diagnosis of dementia. Resident #24's clinical record documented a Standard Placement Determination dated 03/01/2023, but lacked an annual Standard Placement Determination completed in 2024. On 09/11/2024 at 12:09 PM, the Health and Wellness Director verbalized the Health and Wellness Director was only recently made aware Standard Placement Determinations were required annually. The Health and Wellness Director confirmed the resident files for Resident #5, #8, and #24 lacked completed annual Standard Placement Determinations for 2024. The Health and Wellness Director Confirmed Resident #20's Standard Placement Determination document lacked a placement determination, and the Health and Wellness Director should have looked more closely at the physician placement document to ensure it was complete.			
0883 SS= D	Medication - Resident Refusal - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 7. If a resident refuses, or otherwise misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure the physician was notified of a missed dose of medication for 1 of 25 sampled residents (Resident #14). Findings include: Resident #14 Resident #14 was admitted to the facility on 08/08/2024, with a diagnosis of hypertension. Resident #14's September 2024 Medication Administration Record (MAR) documented the following: -Amlodipine Besylate 10 milligram (mg) tablet, take one tablet by mouth every day for hypertension. The start date was 08/15/2024. The discontinued date was 09/08/2024. The last dose administered was 09/07/2024. -Amlodipine Besylate 5 mg	0883	1. Unable to notify physician of missed medication within required 12 hour timeframe. 2. Missed medication administration report will be run prior to the end of each med tech shift, med tech will verify that Medication Refusal form was sent within required timeframe prior to leaving their scheduled shift. 3. Health and Wellness Director or designee will confirm notification of any missed medication was sent to physician within 12 hours. 4. Executive Director, Health and Wellness Director 5. 9/12/2024 6. Attachment B	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	tablet, take one tablet by mouth every day for hypertension. The start date was 09/05/2024. The discontinued date was 09/09/2024. The last dose administered was 09/09/2024. On 09/11/2024 at 1:55 PM, during a medication review, a bubble pack containing Amlodipine Besylate 5 mg tablets was with Resident #14's medications. A Medication Technician confirmed the Amlodipine Besylate 5 mg tablets were discontinued in the facility's electronic medical record system. On 09/11/2024 at 3:30 PM, following a request to review the discontinue order for Amlodipine Besylate 5 mg, the Resident Care Coordinator explained the facility received an order to discontinue Amlodipine Besylate 10 mg and start Amlodipine Besylate 5 mg. The order was dated 09/05/2024. The Resident Care Coordinator explained a Medication Technician later discontinued the Amlodipine Besylate 5 mg by mistake. The Resident Care Coordinator confirmed Resident #14 had not received the ordered dose of Amlodipine Besylate 5 mg on 09/10/2024, and the physician was not notified. 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	0895	1. Resident #14 - MAR corrected 9/12/2024; Resident #25 - 7 day order entered with expiration date in lieu of discontinuing order. Order ended after last dose was to be given; medication did not come up on MAR for administration after 7 days; Resident #11 - Folic acid put back on MAR per physician order 9/12/2024. 2. Health and Wellness Director, Resident Care Coordinator and Medication Technicians certified prior to 9/11/2024 will be re-certified no later than 12/17/2024. Pegasus Medication Policy and Procedure review will be complete by 12/17/2024. 3. Skills checklist will be completed for Health and Wellness Director, Resident Care Coordinator and all med techs to verify understanding of re-training. 4. Health and Wellness Director, Executive Director or designee will monitor for compliance. 5. 9/12/2024 6. Attachment C	12/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	practice registered nurse,including, without limitation, the discontinuation of the 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 clinical record review and interview, the Administrator failed to ensure the Medication Administration Record (MAR) was accurate for 3 of 25 sampled residents (Resident #14, #25, and #11). Findings include: Resident #14 Resident #14 was admitted to the facility on 08/08/2024, with a diagnosis of hypertension. Resident #14's September 2024 Medication Administration Record (MAR) documented the following: - Amlodipine Besylate 5 milligram (mg) tablet, take one tablet by mouth every day for hypertension. The start date was 09/05/2024. The discontinued date was 09/09/2024. The last dose administered was 09/09/2024. A physician's order dated 09/05/2024, documented Amlodipine Besylate 5 mg, take one tablet by mouth every day for hypertension. Note: Stop Amlodipine 10 mg daily. On 09/11/2024 at 3:30 PM, the Resident Care Coordinator explained the facility received an order to discontinue Amlodipine Besylate 10 mg and start Amlodipine Besylate 5 mg. The Resident Care Coordinator explained a Medication Technician later discontinued the Amlodipine Besylate 5 mg by mistake. The Resident Care Coordinator confirmed the MAR was inaccurate and did not match the physician's order. Resident #25 Resident #25 was admitted to the facility on 03/17/2023, with diagnoses including mild cognitive impairment, depression and bronchitis. Resident #25's September 2024 MAR documented Levofloxacin 500 milligram (mg) tablet. Take one tablet by mouth every day for pneumonia, unspecified organism. A physician's order dated 08/28/2024, documented Levofloxacin 500 mg tablet. Take one tablet by mouth every day for seven days. On 09/11/2024 at 1:44 PM, the Medication Technician confirmed the resident's MAR was inaccurate based on the physician's order completing administration of the medication after seven days and verbalized			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	the medication should have been removed from the MAR to avoid confusion. Resident #11 Resident #11 was admitted to the facility on 10/27/2023, with diagnoses including hypertension, arthritis and hypothyroid. A physician's order dated 04/18/2024, documented Folic acid 1 mg tablet, take one tablet by mouth once daily. During the medication review, the medication available on the medication cart was Folic acid 1 mg tablet take one tablet by mouth once daily. Resident #11's September 2024 MAR lacked documented evidence of Folic acid 1 mg tablet. On 09/11/2024 at 3:31 PM, the Resident Care Associate confirmed the Folic acid for Resident #11 should be on the MAR as the physician had not discontinued the order. Severity: 2 Scope: 1			
0250 SS= F	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation and interview, the facility failed to ensure 1) the kitchen floors, walls, shelving, appliances, and preparatory surfaces were free of grime, grease, trash, sticky residue, and food debris, 2) the high temperature dishwasher reached the appropriate temperature to sanitize dishes, and 3) test strips to test the quaternary ammonium sanitizer (quat) were functional to ensure the appropriate amount of sanitizer was present in the quat buckets and three compartment sink to ensure proper cleaning and sanitizing of surface areas used to prepare food. This deficient practice in the kitchen where food was prepared and stored had the potential to affect the entire census. Findings include: Cleanliness of Kitchen On 09/11/2024 at 8:15 AM, during a tour of the kitchen several non-food contact surfaces were heavily soiled and required a	0250	1) Internal cleaning completed by community staff on 9/14/2024, professional cleaning scheduled for 11/21, 11/22/2024. (Quote Attached) Dishwasher was out of service day of inspection; vendor had been called because equipment was not meeting minimum rinse temperature. Repair completed on 9/11/2024 (Service call document attached). Correct test strips located near 3 compartment sink, staff has been retrained on which strips are to be used and how to read. (see attached Test Strip Log) Cleaning schedule has been re-implemented (cleaning logs attached) 2) Dining Service Director will ensure cleaning schedule is followed and schedule professional cleaning quarterly or as needed. 3)Dining Service Director, Executive Director or designee will monitor dishwasher temp, test strips and cleanliness daily. 4) Dining Service Director 5) 11/22/2024 6) Attached D	11/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	professional cleaning. The floors and walls through-out the kitchen, cooking, and dishwashing areas under mounted equipment were heavily soiled with grease and food debris. The kitchen floors underneath equipment, including the cook's line, were soiled with grease, food debris, and trash. Counters and shelves throughout the kitchen were heavily soiled with grease and food debris. A slow cooker filled with oatmeal was streaked and splattered on the outside with a brownish red food substance. The counter around the slow cooker was splattered with the same substance. The interior surface of the juice machine was soiled with sticky juice residue. On 09/11/2024 at 8:36 AM, the Cook verbalized the kitchen should be cleaned daily, at the end of each shift. Cleaning would include sweeping and mopping the floors daily and pulling out the moveable shelves and equipment to clean weekly. Appliances should be cleaned weekly. On 09/11/2024 at 8:45 AM, the Dining Director verbalized the floors, walls, shelves, counters, and appliances were heavily soiled with grease, grime, food debris, and trash. The Dining Director verbalized the floors should be swept and mopped daily, the shelves and counters should be cleaned and sanitized daily, the appliances and shelves should be cleaned and pulled out weekly for cleaning, and the juice machine should be cleaned every evening. The Dining Director verbalized the cleaning was not being completed daily and weekly as required and confirmed the kitchen was dirty and needed a professional deep clean. The Dining Director verbalized there was a weekly cleaning schedule, however the schedule was not being followed and a cleaning log was not maintained. The facility policy titled "Sanitation Overview," revised 01/01/2022, documented food preparation and serving areas must be cleaned on a regular basis. A monthly cleaning schedule for deep cleaning should be maintained and followed. All items on the cleaning schedule must be completed as scheduled and checked off. High Temperature Dishwasher On 09/11/2024 at 8:20 AM, the Dining Director operated the high temperature dishwasher twice. The temperature rose to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	173 degrees during the high temperature rinse both times. The dishwasher failed to reach a temperature of 180 degrees, a temperature required to sanitize. On 09/11/2024 at 8:21 AM, the Dining Director verbalized the temperature was required to reach 170 degrees to effectively sanitize the dishes. The Dining Director was not aware the temperature needed to reach 180 degrees to effectively sanitize. A posting located on the side of the dishwasher documented manufacturers information: Wash: 150 degrees Rinse: 180 degrees Quat Sanitizer On 09/11/2024 at 8:30 AM, the quat bucket used to wipe down surfaces where food was prepared was tested by the Dining Director with a purple test strip. The strip failed to read. On 09/11/2024 at 9:02 AM, the quat sanitizer was tested in the three compartment sink by the Dining Director with a purple test strip. The test strip failed to read. An infographic mounted to the wall behind the three compartment sink documented a picture of the test strips required to test the quat sanitizer. The strips were a light orange color and the color range for testing was orange, indicating 0 parts per million (ppm) to brown, to teal, indicating 500 ppm. The efficacy range for sanitation was 140-400 ppm and the color range was shown to be brown to dark teal. On 09/11/2024 at 9:03 AM, the Dining Director reviewed the infographic mounted on the wall and retrieved the correct strips. The Dining Director remarked the strips were the correct strips for the quat sanitizer buckets as well. The Dining Director tested the sanitizer connected to the three compartment sink with the correct test strip. The strip read bright teal blue, indicating the sanitizer was reading at over 500 ppm and was too concentrated. On 09/11/2024 at 11:07 AM, the Executive Director (ED) verbalized the strips used for testing the quat sanitizer were not effective because they had been dropped in water at some point and were yielding false results. The ED verbalized the Dining Director used new strips and the sanitizer in the three compartment sink was reading in range. The ED was not sure how long the kitchen staff had been using the ineffective strips for testing. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured in 1 of 7 resident rooms containing oxygen cylinders (Room #311). Findings include: On 09/11/2024 at 11:22 AM, Room 311 contained six e-size oxygen cylinders secured and one e-size oxygen cylinder sitting directly on the floor, unsecured. On 09/11/2024 at 11:22 AM, the Maintenance Director confirmed the oxygen tank was not	0690	1) Room #311 Oxygen tank was secured day of inspection- 9/11/2024 2) Residents that use oxygen will have a note in service plan to alert Care Partners to check daily that they are secured. 3) Health and Wellness Director, Resident Care Coordinator or designee will ensure that task (created by service plan) to verify oxygen cylinders are secured will be addressed daily. 4) Health and Wellness Director, Resident Care Coordinator or Executive Director 5) 9/11/2024	09/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	secured and verbalized oxygen tanks should be kept secured. Severity: 2 Scope: 1			
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 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 a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on clinical record review, document review and interview, the facility failed to ensure an annual general physical examination with a review of systems was completed timely for 1 of 25 sampled residents (Resident #21). Findings include: Resident #21 Resident #21 was admitted to the facility on 08/03/2023, with diagnoses including aortic stenosis and hypertension. Resident #21's clinical record documented a physical exam completed on 08/02/2023. Resident #21's clinical record lacked documented evidence of a physical exam completed for 2024. On 09/11/2024 at 11:20 AM, the Wellness Director confirmed Resident #21 did not have a completed annual physical for 2024. Severity: 2 Scope: 1	0859	1. Resident #21 physical dated 9/4/2024 was placed in chart 2. All residents will have physical with review of systems in completed and documentation in chart upon move in and annually. 3. Health and Wellness Director or designee will track all existing and new resident charts to verify physical is completed upon move in and annually. 4. Health and Wellness Director, Resident Care Coordinator or Executive Director 5. 11/18/2024 6. Attachment E	11/18/2024
0874 SS= D	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 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.	0874	1. Resident #10 pharmacy recommendations from 3/14/2024 and 6/6/2024 reviews were addressed with physician on 08/12/2024; Resident #11 pharmacy recommendation from 6/6/2024 review was addressed with physician on 10/24/2024; Resident #15 pharmacy recommendation from 6/6/2024 review was addressed with physician on 10/2/2024 2. Executive Director will ensure that Health and Wellness Director or designee informs physician of pharmacy any recommendation (s) after medication profile review is completed for any resident within 72 hours	10/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	Inspector Comments: Based on record review, document review and interview the Administrator failed to ensure a resident's provider was informed within 72 hours of a recommendation resulting from a medication profile review, performed by a physician, pharmacist or registered nurse for 3 of 25 sampled residents (Resident #10, #11 and #15). Findings include: Resident #10 Resident #10 was admitted to the facility on 08/11/2023, with diagnoses including hyperlipidemia and chronic low back pain. Resident #10's record included Consultation Reports, following a medication profile review, dated 03/14/2024 and 06/06/2024. Resident #10's record lacked documented evidence the resident's provider was notified of the recommendations resulting from the medication profile reviews within 72 hours of the facility receiving the recommendations. On 09/11/2024 at 3:16 PM, the Executive Director explained the facility had faxed the recommendations resulting from a review of Resident #10's medications on 03/14/2024 and 06/06/2024, however the facility had not received any return communication from the provider or confirmation the fax was received by the provider. Resident #11 Resident #11 was admitted to the facility on 10/27/2023, with diagnoses including hypertension, arthritis and hypothyroid. Resident #11's record included Consultation Reports, following a medication profile review, dated 06/06/2024. Resident #11's record lacked documented evidence the resident's provider was notified of the recommendations resulting from the medication profile reviews within 72 hours of the facility receiving the recommendations. Resident #15 Resident #15 was admitted to the facility on 02/01/2023, with diagnoses including hypertension, autistic disorder, and chronic obstructive pulmonary disease. Resident #15's record included Consultation Reports, following a medication profile review, dated 06/06/2024. Resident #15's record lacked documented evidence the resident's provider was notified of the recommendations resulting from the medication profile reviews within 72 hours of the facility receiving the recommendations.		of receipt of pharmacy review. A copy of the recommendation and physician's response will be addressed and kept in resident chart. 3. Executive Director, Health and Wellness Director or designee will review pharmacy review recommendations to ensure they have been sent to physician within 72 hours of receipt. 4. Executive Director 5. 10/24/2024 6. Attachment F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	On 09/11/2024 at 3:16 PM, the Executive Director explained the facility had faxed the recommendations resulting from a review of Resident #11 and #15's medications on 06/06/2024, however the facility had not received any return communication from the provider or confirmation the fax was received by the provider. Severity: 2 Scope: 1			
0876 SS= E	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure Ultimate User Agreements were accurately completed for 9 of 25 residents (Resident #25, #3, #15, #19, #4, #23, #14, #8, and #9). Findings include: Resident #25 Resident #25 was admitted to the facility on 03/17/2023, with diagnoses including mild cognitive impairment, depression and bronchitis. Resident #25's clinical record documented an Ultimate User Agreement completed on 02/22/2023. The Ultimate User Agreement indicated the resident would possess and manage their own medications and lacked a signature from staff, documenting the document was reviewed and accurate. On 09/11/2024 at 8:30 AM, the facility provided a list of residents in the facility possessing and managing their own medications. Resident #25 was not present on the list and the facility provided the Medication Administration Record (MAR) for the resident. The September 2024 MAR for Resident #25 had a variety of medications to be administered to the resident	0876	1. Ultimate User Agreements have been completed/updated for residents #25, #3, #15, #19, #4, #14, #8 and #9. Resident #23 no longer resides at community. 2. Health and Wellness Director or designee will ensure accurate Ultimate User Agreements are completed upon move in or change in medication administration status. 3. Health and Wellness Director or designee will monitor resident charts to verify correct, completed Ultimate User Agreement is present for all residents upon move in and upon change of status. 4. Health and Wellness Director, Resident Care Coordinator 5. 09/13/2024 6. Attachment G	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	throughout the day. The signature line was signed by Medication Technicians, indicating staff were administering the resident's medications to the resident. On 09/11/2024 at 11:41 AM, the Health and Wellness Director confirmed the facility was managing and administering medications to Resident #25 and the resident's Ultimate User Agreement was inaccurate. The Health and Wellness Director explained Ultimate User Agreements were signed by staff indicating a review of the form was done and was accurate. The Health and Wellness Director confirmed Resident #25's Ultimate User Agreement lacked signatures from staff who were to review the accuracy of the form. Resident #3 Resident #3 was admitted to the facility on 12/01/2022, with diagnoses including acute respiratory failure with hypoxemia and dementia. Resident #3's clinical record included an Ultimate User Agreement dated 12/10/2023. The Ultimate User Agreement lacked a signature from facility staff, documenting the form was reviewed and accurate. Resident #15 Resident #15 was admitted to the facility on 02/01/2023, with diagnoses including hypertension, autistic disorder and chronic obstructive pulmonary disease. Resident #15's clinical record included an Ultimate User Agreement dated 01/21/2023. The Ultimate User Agreement lacked a signature from facility staff, documenting the form was reviewed and accurate. Resident #19 Resident #19 was admitted to the facility on 06/12/2024, with diagnoses including memory impairment, dementia and myocardial infarction. Resident #19's clinical record included an Ultimate User Agreement dated 06/06/2024. The Ultimate User Agreement lacked a signature from facility staff, documenting the form was reviewed and accurate. On 09/11/2024 at 11:41 AM, the Health and Wellness Director explained Ultimate User Agreements were signed by staff indicating a review of the form was done and was accurate. The Health and Wellness Director confirmed the Ultimate User Agreements for Resident #3, #15 and #19, in the residents' clinical records, lacked signatures from staff who were to review the form for accuracy. Resident #4 Resident #4 was admitted to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	the facility on 03/20/2024, with diagnoses including atrial fibrillation and hypertension. Resident #4's clinical record included an Ultimate User Agreement dated 03/14/2024. The Ultimate User Agreement lacked a signature from facility staff, documenting the form was reviewed and accurate. Resident #23 Resident #23 was admitted to the facility on 04/15/2024, with diagnoses including chronic kidney disease and dementia. Resident #23's clinical record included an Ultimate User Agreement dated 03/29/2024. The Ultimate User Agreement lacked a signature from facility staff, documenting the form was reviewed and accurate. Resident #14 Resident #14 was admitted to the facility on 08/08/2024, with diagnoses including hypertension and hyperlipidemia. Resident #14's clinical record included an Ultimate User Agreement dated 08/07/2024. The Ultimate User Agreement lacked a signature from facility staff, documenting the form was reviewed and accurate. On 09/11/2024 at 11:41 AM, the Health and Wellness Director explained Ultimate User Agreements were signed by staff indicating a review of the form was done and was accurate. The Health and Wellness Director confirmed the Ultimate User Agreements for Resident #4, #23, and #14, in the residents' clinical records, lacked signatures from staff who were to review the form for accuracy. Resident #8 Resident #8's clinical record documented an Ultimate User Agreement completed on 02/10/2023. The Ultimate User Agreement indicated the resident would possess and manage their own medications and lacked a signature from staff, documenting the document was reviewed and accurate. On 09/11/2024 at 8:30 AM, the facility provided a list of residents in the facility possessing and managing their own medications. Resident #8 was not present on the list and the facility provided the MAR for the resident. Resident #8 was admitted to the facility on 02/05/2021, with diagnoses including atrial fibrillation, hypertension, and dementia. The September 2024 MAR for Resident #8 had a variety of medications to be administered to the resident throughout the day. The signature line was signed by Medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	Technicians, indicating staff were administering the resident's medications to the resident. On 09/11/2024 at 12:12 PM, the Health and Wellness Director confirmed Resident #8's clinical record lacked a signed ultimate user Agreement. The Wellness Director verbalized when Resident #8 was admitted, the resident administered their own medications. Recently the facility began administering Resident #8's medications, but the Health and Wellness Director did not know how long the facility administered medications to Resident #8 without a signed Ultimate User Agreement. On 09/11/2024, the facility provided an Ultimate User Agreement dated 10/02/2024, without a signature from the Community Representative. On 09/11/2024 at 3:41 PM, the Executive Director confirmed the Ultimate User Agreement dated 10/02/2024, was not signed. Resident #9 Resident #9 was admitted to the facility on 11/26/2022, with diagnoses including hypertension, hyperthyroidism, and chronic kidney disease. Resident #9's clinical record documented an Ultimate User Agreement completed on 11/10/2022. The Ultimate User Agreement indicated the resident would possess and manage their own medications and lacked a signature from staff, documenting the document was reviewed and accurate. On 09/11/2024 at 8:30 AM, the facility provided a list of residents in the facility possessing and managing their own medications. Resident #9 was not present on the list and the facility provided the MAR for the resident. The September 2024 MAR for Resident #9 had a variety of medications to be administered to the resident throughout the day. The signature line was signed by Medication Technicians, indicating staff were administering the resident's medications to the resident. Resident #9's clinical record lacked an Ultimate User Agreement for the facility to administer medications to the resident. On 09/11/2024 at 12:06 PM, the Health and Wellness Director confirmed Resident #9's clinical record lacked a signed Ultimate User Agreement. The Wellness Director verbalized when Resident #9 was admitted, the resident administered their own			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	medications. After Resident #9 returned to the facility from a hospital visit, the facility began administering Resident #9's medications, but the Health and Wellness Director did not know how long the facility administered medications to Resident #9 without a signed Ultimate User Agreement. On 09/11/2024, the facility provided an Ultimate User Agreement dated 01/31/2024, signed by the resident and the Health and Wellness Director. On 09/11/2024 at 3:31 PM, the Health and Wellness Director verbalized the Health and Wellness Director and Resident #9 signed the Ultimate User Agreement after 09/11/2024 at 12:06 PM, and the Health and Wellness Director dated the document with 01/31/2024, the day the resident returned from the rehabilitation center. On 09/11/2024 at 4:00 PM, the Executive Director verbalized no documents should ever be back dated. The Executive Director confirmed the Health and Wellness Director back dated Resident #9's 01/31/2024 Ultimate User Agreement. Severity: 2 Scope: 2			
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	0878	1. Resident #6 - medication in cart; Resident #18 - medication in cart; Resident #1 - Medication discontinued on 7/31/2024 medication removed from cart day of inspection; Resident #10 - Change of direction sticker applied to original medication container day of inspection; Resident #3- Change of direction sticker applied to original medication container day of inspection. 2. Health and Wellness Director, Resident Care Coordinator and Medication Technicians certified prior to 9/11/2024 will be re-certified no later than 12/17/2024. Pegasus Medication Policy and Procedure review will be complete by 12/17/2024. 3. Skills checklist will be completed for Health and Wellness Director, Resident Care Coordinator and all med techs to verify understanding of re-training. 4. Executive Director 5. 12/17/2024	12/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	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 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 observation, interview, and record review, the Administrator failed to ensure medications were on-site and available to administer to a resident for 3 of 25 sampled residents (Resident #6, #18, and #1) and ensure medication containers indicated a change in medication for 2 of 25 sampled residents (Resident #10 and #3). Findings include: Resident #6 Resident #6 was admitted to the facility on 02/19/2024, with diagnoses including fracture of sacrum, dependence on supplemental oxygen and hypothyroidism. Resident #6's September 2024 Medication Administration Record (MAR) documented Tramadol Hydrochloride (HCl) 4 milligram (mg). Take one tablet by mouth every day as needed for severe pain. A physician's order dated 03/12/2024, documented Tramadol HCl 4 mg. Take one tablet by mouth every day as needed for severe pain. On 09/11/2024 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	1:32 PM, the Medication Technician could not locate Tramadol for Resident #6 and verbalized the resident could experience being uncomfortable and in constant pain due to the medication not being on-site and available to administer to the resident. The Medication Technician confirmed Tramadol was not on-site and available to administer to Resident #6. Resident #18 Resident #18 was admitted to the facility on 05/22/2024, with diagnoses including short term memory loss, history of breast cancer and history of psoriasis. Resident #18's September 2024 MAR documented Memantine HCl 10 mg tablet. Take on tablet by mouth two times a day. The MAR lacked administration confirmation of the medication every day for the month of September 2024. A physician's order dated 07/24/2024, documented Memantine HCl 10 mg tablet. Take on tablet by mouth two times a day for 360 days. On 09/11/2024 at 1:40 PM, the Medication Technician confirmed Resident #18's Memantine was not on-site and available to administer to the resident and could not verbalize how long the medication had not been on-site. Resident #1 Resident #1 was admitted to the facility on 04/12/2024, with a diagnosis of hypertension. A physician order dated 05/09/2024, documented Atorvastatin Calcium 20 mg oral tablet. Take one tablet by mouth at bedtime. Resident #1's September 2024 MAR, documented Atorvastatin Calcium 20 mg tablet. Take one tablet by mouth at bedtime. On 09/11/2024 at 2:05 PM during a medication review, Resident #1's Atorvastatin Calcium was not on site. The Resident Care Associate verbalized the Resident #1's Atorvastatin Calcium was not in the medication drawer. The Resident Care Associate explained the Atorvastatin was not an active medication, as it had been discontinued on 07/31/2024. The Resident Care Associate confirmed the facility continued to administer the medication from 07/31/2024 to 09/10/2024, and the MAR indicated the medication was an active order. The facility was unable to provide a discontinue order for Resident #1's Atorvastatin Calcium. Resident #10 Resident #10 was admitted to the facility on 08/11/2023, with diagnoses including			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(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
	hyperlipidemia and chronic low back pain. Resident #10's MAR documented Ondansetron HCl 4 mg tablet, take one tablet by mouth every six hours as needed for nausea, vomiting. A physician's order dated 09/06/2024, documented Ondansetron HCl 4 mg tablet, take one tablet my mouth every six hours as needed for nausea, vomiting. On 09/11/2024 at 2:15 PM, during a review of Resident #10's medications and in the presence of a Medication Technician, Ondansetron 4 mg tablets were with Resident #10's medications. The label on the container of Ondansetron tablets documented take one tablet once in a day. The container lacked an order change sticker. The Medication Technician confirmed the Ondansetron should have a change order sticker attached to it as the label did not match Resident #10's MAR or the physician's order. Resident #3 Resident #3 was admitted to the facility on 12/01/2022, with diagnoses including acute respiratory failure with hypoxemia, and dementia. Resident #3's September MAR and Physicians's order dated 05/09/2024, documented Donepezil hydrochloride (HCl) 10 mg tablet, take one tablet by mouth once daily at 4:00 PM for Alzheimer's disease. During the medication review, Resident #3's available medication documented Donepezil HCl 10 mg, take one tablet every day in the evening for 90 days. On 09/11/2024 at 1:49 PM, the Medication Technician confirmed a change order sticker needed to be placed on the Donepezil HCl 10 mg tablet bubble pack. Severity: 2 Scope: 1			