Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9541	A. BUILDING _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092

(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 an annual State Licensure survey on 12/28/22. The State Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 120 total Residential Facility for Group beds, with 90 beds for elderly and disabled persons and/or provides assisted living services and 30 beds for care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 95. Twenty resident files were reviewed, and twelve employee files were reviewed. The facility received a grade of A. 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 deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: LISA MARIE CAMPBELL	Title: Administrator	Date: 01/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9541	A. BUILDING _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092

(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
0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure a medication technician maintained a current first aid and cardiopulmonary resuscitation (CPR) training for 1 of 12 sampled employees (Employee #6). Findings include: Employee #6 Employee #6 was hired as a medication technician on 04/23/01. The employee's file contained a first aid and CPR training certificate dated 01/22/19 and a first aid and CPR training certificate dated 03/01/22, beyond the two-year expiration date. On 12/28/22 at 12:34 PM, the Administrator confirmed Employee #6 had not received the required training prior to previous training expiration. Severity: 2 Scope: 1	0106	1. Employee #6 prior CPR expired 11/2021, was renewed 3/1/2022. 2. Business Office Director, Executive Director or designee will audit employee files monthly to ensure CPR/First Aid certifications are renewed prior to expiration date. 3. Business Office Director, Executive Director or designee will audit employee files monthly for compliance. 4. Business Office Director, Executive Director 5. 3/1/2022 6. Exhibit A	03/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9541	A. BUILDING _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092

(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
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, clinical record review, interview and document review, the facility failed to ensure a discontinued medication was destroyed for 1 of 20 sampled residents (Resident #19). Findings include: Resident #19 Resident #19 was admitted to the facility on 04/15/19, with diagnoses including major depressive disorder, dementia, and hypercholesteremia. A physician's order dated 12/20/22, documented Zofran 4 milligrams (mg), one tablet by mouth every four hours as needed for nausea. Resident #19's December 2022 Medication Administration Record (MAR), documented Zofran 4 mg, take one tablet by mouth every four hours as needed for nausea. Discontinue date 12/21/22. Resident #19's medication bin contained a bottle of Zofran 4 mg. On 12/28/22 at 11:43 AM, the Health and Wellness Coordinator verbalized the Zofran 4 mg was discontinued on 12/21/22 and should not have been stored with the resident's current medications. The Health and Wellness Coordinator confirmed the Zofran 4 mg should have been removed from Resident #19's medication bin and destroyed. Severity: 2 Scope: 1	0885	1. Resident #19 discontinued medication removed from cart at time of inspection. 2. Health and Wellness Director or designee will remove all discontinued medications when d/c order is received. 3. Health and Wellness Director or designee will review resident medications at each med pass to verify only current medications are available on the med cart. 4. Health and Wellness Director 5. 12/28/2022 6. Exhibit B	12/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9541	A. BUILDING _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092

(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
0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, clinical record review, and document review, the facility failed to ensure an over-the-counter medication had a resident name and/or ordering physician's name on the label for 1 of 20 sampled residents (Resident # 3). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/17/21, with diagnoses including congestive heart failure, osteoporosis, and hypothyroidism. Resident #3's Medication Administration Record (MAR) dated December 2022, documented EB-N3 DR 6 milligram (mg)-70 mg-4 mg-1.3 mg. Give one capsule by mouth one time per day for memory. The medication was located in Resident #3's medication bin, however, lacked documented evidence of the resident's name and the ordering physician's name on the medication. On 12/28/22 at 11:19 AM, the Lead Medication Technician confirmed the EB-N3 DR 6 milligram (mg)-70 mg-4 mg-1.3 mg did not have the name of the resident and ordering physician on the medication bottle and verbalized the names needed to be present on the bottle to identify to which resident the medication belonged. Severity: 2 Scope: 1	0923	1. Resident #3 EB-N3 DR 6 Mg-70mg-1.3mg OTC container was labeled with resident name and name of ordering physician day of inspection. 2. Health and Wellness Director or designee will label all OTC medications with resident name and name of ordering physician upon receipt. 3. Health and Wellness Director, Medication Technician or designee will review resident medications at each med pass to verify all OTC medications are properly labeled. 4. Health and Wellness Director or Executive Director 5. 12/28/2022 Exhibit C	12/28/2022
1540 SS= F	Cultural Competency Training Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 11 of 11 sampled employees required to obtain cultural competency training (Employees #1, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13). Findings include: Employee #1 Employee #1 was hired as an Executive Director with a start date of 05/23/22. The	1540	1. Cultural Competency training for employees #1, #3, #4, #5, #6, #7, #8, #9, #10 #12 and #13 has been completed. Initial CC training will be completed within 30 days of hire and Annual training will be completed prior to the expiration date of current certificates. 2. Executive Director, Business Office Director or designee will coordinate initial and annual Cultural Competency training for all employees to be completed timely. 3. Executive Director, Business Office	12/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9541	A. BUILDING _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092

(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
	personnel record for Employee #1 had a cultural competency training certificate dated 10/09/22. Employee #3 Employee #3 was hired as Life Enrichment Director with a start date of 11/30/17. The personnel record for Employee #3 had a cultural competency training certificate dated 10/10/22. Employee #4 Employee #4 was hired as Care Partner with a start date of 08/29/22. The personnel record for Employee #4 had a cultural competency training certificate dated 10/09/22. Employee #5 Employee #5 was hired as Medication Technician with a start date of 08/13/22. The personnel record for Employee #5 had a cultural competency training certificate dated 10/10/22. Employee #6 Employee #6 was hired as Medication Technician with a start date of 04/23/01. The personnel record for Employee #6 had a cultural competency training certificate dated 10/08/22. Employee #7 Employee #7 was hired as Medication Technician with a start date of 12/14/21. The personnel record for Employee #7 had a cultural competency training certificate dated 10/09/22. Employee #8 Employee #8 was hired as Care Partner with a start date of 06/10/07. The personnel record for Employee #8 had a cultural competency training certificate dated 10/11/22. Employee #9 Employee #9 was hired as Health and Wellness Director with a start date of 08/23/07. The personnel record for Employee #9 had a cultural competency training certificate dated 10/08/22. Employee #10 Employee #10 was hired as Care Partner with a start date of 05/15/17. The personnel record for Employee #4 had a cultural competency training certificate dated 10/11/22. Employee #12 Employee #12 was hired as Medication Technician with a start date of 09/03/08. The personnel record for Employee #12 had a cultural competency training certificate dated 10/09/22. Employee #13 Employee #13 was hired as Care Partner with a start date of 02/16/22. The personnel record for Employee #13 had a cultural competency training certificate dated 10/10/22. On 12/28/22 at 12:28 PM, the Administrator confirmed the cultural competency training for all employees was completed late. Severity: 2 Scope: 3		Director or designee will audit all new employee files within 30 days of hire to verify all required training is completed and will track renewal dates for annual training to verify completion in a timely manner. 4. Business Office Director 5. 12/28/2022 6. Exhibit D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9541	A. BUILDING _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	**5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092**

(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