STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9975	A. BUILDING _____ B. WING _____	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MEADOWS RESIDENTIAL CARE HOME	13495 STONEY BROOK DR, RENO, NEVADA ,89511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted at your facility on 09/19/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Groups beds for elderly and disabled persons, and/or persons with mental illness, Category II residents. The census at the time of the survey was ten. Ten resident records and four employee records 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	0000		
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 and interview, the facility failed to ensure an expired medication was removed from use for 1 of 10 residents (Resident #4). Resident #4 Resident #4 was admitted to the facility on 07/09/20 with diagnoses including cerebral atherosclerosis, hypothyroidism, osteoarthritis, chronic obstructive pulmonary disease, and dementia. A physician order dated 03/18/22, documented cranberry softgels, 4200 milligrams, give one softgel by mouth, once a day. The over-the-counter	0885	1. **The correction of the specific finding:** The facility failed to ensure an expired medication was removed from use. The specific finding for resident #4 was found to have been affected by the deficient practice. The manager immediately notified the family of the expiration of the supplement that afternoon. The same day at 4.30 pm, the family delivered a new container of cranberry 4200 mg softgels, expiration date is (11/2024). The expired medication was discarded as described in our medication management plan immediately that evening	09/19/2023

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	cranberry softgels located in Resident #4's medication tray had an expiration date of 08/2023. Resident #4's Medication Administration Record dated September 2023, documented the cranberry softgels had been administered daily to Resident #4 from 09/01/23 to 09/19/23 at 8:00 AM. On 09/19/23 at 2:44 PM, the Caregiver confirmed the cranberry softgels administered to Resident #4 had an expiration date of 08/2023 and should gave been removed from the resident's tray and reordered. Severity: 2 Scope: 1		1. **The measures or systematic change is put into place to ensure the deficient practice does not recur:** The manager/administrator will carefully review the MARs and the medication label including the expiration date at the beginning of each month and at the time of medication is delivered. 3. **The corrective action is monitored to ensure the deficient practice will not recur** by reviewing the expiration date of all over-counter medication before receiving it from the family members. 4. **The manager and the administrator is the responsible persons** to ensure and re-ensure the plan of the correction is implemented. 5. The date of the corrective	

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			action is completed: 9/19/2023 1. No support documents	
0930 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation and interview, the facility failed to ensure resident records were secured causing the potential for unauthorized access to the records. Findings include: On 09/19/23 at 10:33 AM, a vertical file folder rack located on the counter above the locked cabinet containing resident records, contained three unsecured resident records. Each record contained hospice information of the resident to include plans of care with resident diagnoses and resident medication lists. On 09/19/23 at 10:34 AM, the Caregiver confirmed the hospice resident records were not secured and contained resident plans of care and medication lists. The Caregiver confirmed due to the resident information contained in the records the records should have been secured. Severity: 2 Scope: 1	0930	1. **The correction of the specific finding by the deficient practice:** The hospice folders were immediately put away in a locked cabinet. At 8 am on 9/19/2023, the manager and employees went over the resident hospice folders (to see what documents were import to keep in resident folder), however the facility failed to ensure that the hospice folder resident records were put away after viewing in a secured cabinet causing potential for unauthorized access to the records. 1. **The measures or systematic change** is put into place to ensure the deficient practice does not recur: The manager, administrator and all staff will ensure the privacy practice is efficient and all resident hospice folders will be put away immediately.	09/19/2023

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			3. **The corrective action is monitored** to ensure the deficient practice will not recur by ensuring with all staff to perform the privacy practice tightly and strictly. 4. **The manager and the administrator** is the responsible persons to ensure and re-ensure the plan of correction is implemented. 5. The date of the corrective action is completed: 9/19/2023 1. No support documents	
1540 SS= D	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103.	1540	1. **The correction of the specific finding by the deficient practice:** One of our employees failed to ensure the cultural competency certificate was on file during the time of inspection. The facility reached out to the Nevada Training Department and previous employer to get the certificate but the certificate was not found. The facility assigned a new training for this employee on October 20, 2023 (see the support document)	10/02/2023

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	Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1 of 4 employees completed initial cultural competency training within 30 days of hire (Employee #4). Findings include: Employee #4 Employee #4 had a hire date of 05/16/23 as Caregiver/Medication Technician. Employee #4's personnel record lacked documented evidence of initial cultural competency training. On 09/19/23 at 3:05 PM, Employee #4 verbalized having difficulty obtaining the cultural competency certificate from Employee #4's previous employer. Employee #4 confirmed Employee #4's personnel record lacked documented evidence of initial cultural competency training. Severity: 2 Scope: 1		1. **The measures or systematic change is put into place** to ensure the deficient practice does not recur: The manager, administrator and all staff will ensure all of the required documents will be submitted during the hiring process. 3. **The corrective action is monitored** to ensure the deficient practice will not recur by ensuring all training to be up-to-date and all documents are onsite in the employee folders at all times. The time record of the expiration of all employee training will be on the management calendar to monitor the practice. 4. **The manager and the administrator** is the responsible persons to ensure and re-ensure the plan of the correction is implemented. 5. The date of the corrective	

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			action is completed: 10/02/2023 at 9.40am (see the support document) 1. See supporting document 1	