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 _____	08/22/2024

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 08/22/2024. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was nine. Nine resident records and four employee files were reviewed. The facility received a grade of B. 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 deficiencies were identified:	0000		
1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the	1830	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding for employee personnel file 1 and 2 lacking documented evidence for 15 hours of infection control training. The employees were trained for 15 hours from the Centers for Disease Control and Prevention of the United States Department of Health and Human Services website from Module 1 to Module 15 from https://www.train.org/cdctrain/home.	10/12/2024

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	training. Inspector Comments: Based on personnel file review and interview, the primary and secondary infection control staff failed to complete the required 15 hours of infection control training (Employee #1 and #2). Findings include: Employee #1 Employee #1 was hired by the facility as the Administrator with a start date of 05/02/2024. Employee #1's personnel file lacked documented evidence 15 hours of infection control training had been completed. Employee #2 Employee #2 was hired by the facility as a Medication Technician with a start date of 05/16/2023. Employee #2's personnel file lacked documented evidence 15 hours of infection control training had been completed. On 08/22/2024 at 12:38 PM, the Administrator explained the Administrator and Employee #2 were the primary and secondary infection control staff. The Administrator confirmed the required infection control training was not completed. Severity: 2 Scope: 3		2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator will ensure that the new employee will be trained within 3 months after being designated and annually thereafter. Therefore, next year these two employees will be trained and certified for at least 15 hours (from Module 1 to 15) by Oct 12, 2025 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The administrator will monitor all annual employee training including annual infection control training from the CDC learning websites and certificates from each module will be recieved. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of the correction is implemented. 5) The date the corrective action will be completed (MUST	

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			INCLUDE); AND Answer: The date of the corrective action was completed: 10/12/2024. 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: 1) Employee 1 certificates from each module (module 1-15). 2) Employee 1 cerficates from each module (module 1-15).	
0276 SS= D	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation and interview, the facility failed to ensure canned goods were not stored in the facility's pantry beyond the best by date. Findings include: On 08/22/2024 at 9:16 AM, the following items were found in the facility's food pantry: -A can of brown gravy. The best by date was 06/16/2023. -Two cans of creamy tomato soup. The best by date was 12/05/2023. On 08/22/2024 at 9:16 AM, a Caregiver confirmed the best by dates printed on the can of brown gravy and two cans of creamy tomato soup had passed and should no longer have been	0276	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding for expired canned goods. The expired canned goods were discarded during the survey time on 08/22/2024. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator will conduct monthly audits of expiration dates of other food supplies, such as sauces and condiments.	10/03/2024

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	kept in the facility's pantry. On 08/22/2024 at 3:29 PM, the Administrator confirmed food items should not be stored in the facility's pantry past the best by date printed on the food item. Severity: 2 Scope: 1		3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: Monitoring the expiration dates of all food supplies, sauce and other condiments monthly. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of the correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 8/22/2024. 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: No support documents.	
0430	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for	0430	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding for failing to	08/22/2024

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	residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on record review and interview, the facility failed to ensure smoke detectors were tested on a monthly basis. Findings include: The Smoke Detector log revealed the last smoke detector test was conducted in 2022. On 08/22/2024, the Administrator reviewed the Smoke Detector log and confirmed the facility lacked documented evidence of smoke detector tests for 2023 or 2024. Severity: 2 Scope: 3		ensure smoke detectors were tested and recorded on a monthly basis. The smoke detectors in all bedrooms, hallways were tested and recorded immediately. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator ensures a designated employee will test and record smoke detectors by the 5th of each month. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The corrective action will be monitored to ensure the deficient practice will not recur by adding a reminder of the smoke alarm test on the 1st of the month to the employee calendar displayed at the care home. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of the correction is implemented. 5) The date the corrective action	

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			will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 8/22/2024. 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: Documented smoke alarm test on 8/22/2024 and 9/1/2024.	
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the 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 record review, document review and interview, the	0895	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding for resident #7 was found to have been affected by deficient practice: The written correction for Senna was added on the MAR as "**Senna Plus 8.6 mg-50 mg tablet".** 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator will carefully review the MARs and the medication labels compare them to doctor orders immediately after receiving the order. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The corrective action will be monitored to ensure the	08/22/2024

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	Administrator failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 9 sampled residents (Resident #7). Resident #7 Resident #7 was admitted to the facility on 11/04/2023, with diagnoses including mild cognitive impairment, anxiety and insomnia. During the medication review the following medication was available, however was not documented on the MAR. -Senna Plus 8.6 milligram (mg) - 50 mg tablet, take one tablet twice a day as needed for constipation A physician's order dated 12/14/2023 documented Senna Plus 8.6 mg - 50 mg tablet, take one tablet twice a day as needed for constipation. On 08/22/2024 at 2:30 PM, the Owner confirmed Resident #7's MAR needed to be updated to reflect the current physician's orders and medications onsite. Severity: 2 Scope: 1		deficient practice will not recur by reviewing the doctor's order, label, and the medication to ensure accuracy immediately. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of the correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 8/22/2024. 6) You must attach all supporting documents into the system (MUST INCLUDE); 1. Answer: No support documents.	
0936 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	0936	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS) Answer: The correction of the specific finding by deficient practice: The two step-TB test will need to be completed upon admission to the facility.	08/29/2024

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	limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on document review, clinical record review and interview, the facility failed to ensure 1 of 9 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 11/04/2023, with diagnoses including mild cognitive impairment. Resident #7's clinical record contained a one step TB test given on 07/28/2023 and lacked a read date. The clinical record lacked a second step TB test. On 08/22/2024 at 12:33 PM, the Owner verbalized a two step TB was required to be completed upon admission to the facility. The Owner confirmed Resident #7 lacked a read date for the one step and did not have a second step TB test completed. Severity: 2 Scope: 1		The facility failed to ensure both steps of TB testing were completed and kept on the resident file. The QuantiFERON blood test was done to correct this citation. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator will review all TB test documents and not allow the resident to be admitted prior to completion of the two steps of the TB test or the QuantiFERON blood test. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The administrator will review admission documents carefully prior admission 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction	

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			is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 08/29/24. 6) You must attach all supporting documents into the system (MUST INCLUDE 1. Answer: Support documents: Resident #7 Negative result with the QuantiFERON TB test document.	
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited	1300	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding by the deficient practice: The facility lacked the required nondiscrimination statement on the Internet website used to market the facility. The administrator immediately updated the nondiscrimination statement on the bottom of the website's main page as shown to the public as https://www.southmeadowscarehome.com/. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice	08/22/2024

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	discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments: Based on observation and interview, the facility failed to post a nondiscrimination statement on an Internet website used to market the facility. Findings		does not recur (MUST ADDRESS); Answer: The administrator will always ensure that the nondiscrimination statement is displayed on the website. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The corrective action will be monitored to ensure the deficient practice will not recur by the administrator. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is implemented. 5) The date the corrective action	

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	include: On 08/22/2024 at 9:00 AM, the facility lacked the required nondiscrimination statement on the Internet website used to market the facility. On 08/22/2024 at 12:49 PM, the Administrator confirmed the facility's website lacked the required statement related to nondiscrimination. Severity: 1 Scope: 3		will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 8/22/2024. 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: Support documents: a snapshot of the nondiscrimination statement.	
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 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	1700	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The Administrator failed to obtain an initial Standard Physician Assessment and Placement Determination upon admission, . Resident #7's clinical record documented a Standard Placement Determination completed 11/07/2023, however was completed three days after Resident #7's admission. We will obtain an initial Placement Determination upon admission for all new admission and annually thereby. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not	08/22/2024

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	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 an initial Standard Physician Assessment and Placement Determinations for 1 of 9 sampled residents with a diagnosis of dementia (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 11/04/2023, with a diagnosis of mild cognitive impairment, anxiety and insomnia. Resident #7's clinical record documented a Standard Placement Determination completed 11/07/2023, however was completed three days after Resident #7's admission. On 08/22/2024 at 12:33 PM, the Owner confirmed Resident #7's Standard Placement Determination was completed on 11/07/2023, three days late and should have had one upon admission. Severity: 2 Scope: 1		recur (MUST ADDRESS); Answer: The administrator will ensure that the Standard Physician Assessment and Placement Determinations will be completed and received upon admission. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: By reviewing all admission documents and not allowing a new admission until all documents are submitted to the facility. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed:	

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 _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			8/22/2024. 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: No support documents.	