DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT ESTATES	**222 EAST PATRIOT BLVD, RENO, NEVADA ,89511**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey and a complaint (CPT) investigation conducted in your facility on 02/07/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 134 Residential Facility for Group beds, which provides assisted living services for elderly and disabled persons and/or persons with Alzheimer's disease, 57 Category I residents, 45 Category II (non-Alzheimer's) and 32 Category II (Alzheimer's) residents. The census at the time of the survey was 102. There were 25 resident files and 13 employee files reviewed. The facility received a grade of D. 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. There were two Complaints investigated. Complaint #67601 with the allegation the facility was understaffed was substantiated (see TAG Y0966). The following allegations could not be substantiated due to lack of evidence: Allegation #1: A resident had pressure sores or urinary tract infection due to understaffing. Allegation #2: A resident was not assessed and monitored. Allegation #3: A resident was not treated with dignity. Allegation #4: A resident's call bell was not answered timely. Allegation #5: A resident was left wet for extended periods of time.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: DOUGLAS S HOPKINS | Title: Administrator | Date: 03/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Allegation #6: A resident was left soiled for extended periods of time. Allegation #7: A resident was not offered water. Complaint #67556 with the allegation the facility was understaffed was substantiated (see TAG Y0966). The following allegations could not be substantiated due to lack of evidence: Allegation #1: A resident was left soiled for an extended period. Allegation #2: A resident was not turned/positioned or bathed. Allegation #3: A resident was not groomed adequately. The investigation into the allegations included the following: Observations of residents in resident rooms and common facility areas, and staff and resident interactions. Interviews with nine residents, three resident assistants, a medication aide, and the Administrator. Clinical record review including diagnoses, incontinent care, activities of daily living (ADL) assessments and logs of ADL care, and bathing schedules. Policy review including team staffing approach, resident ADL's: incontinent care, and call system. Review of staffing schedules and daily census for December 2022, January 2023, and February 2023. The following regulatory deficiencies were identified.			

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0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure all windows capable of being opened in the facility to provide ventilation for the facility were screened to prevent the entry of insects. Findings include: On 02/06/23, the following resident rooms lacked screens or had defective screens. - Room 124 - the window screen was not connected to the frame, leaving an opening. - Room 223 - the window screen was torn, leaving an opening. - Room 109 - the window screen was not connected to the frame, leaving an opening. - Room 265 - the window screen covering the left pane was missing. On 02/06/23 between 3:00 PM and 3:13 PM, the Director of Environmental Services confirmed the window screen concerns. Severity: 2 Scope: 1	0179	1. All windows were visually checked and the screens that were identified as lacked screens or defective were replaced. 2. The facility will perform a monthly visually of all window screens to ensure they are in place and not defective. 3. The facility will review need for continued audits on a monthly basis as part of QA process 4. Corrected Date: 3/7/2023	03/07/2023
0252 SS= F	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Citation Text for Tag 0252, Regulation I49N Mazy, Alicia Based on observation, interview and document review, the facility failed to ensure 1) food was labeled upon placing in the refrigerator, 2) to discard expired food, 3) to ensure staff wore hairnets, 4) a kitchen aid mixer was not used to store gloves and paper, and 5). to have quat buckets available in the kitchen with proper sanitizing agents. Findings include: Labeled Food On	0252	1. The two blocks of cheese slices were removed from the kitchen. All kitchen staff were educated on hairnet usage and put on hairnets. The paper products from the stand mixer were placed in the appropriate storage area. Quat Buckets were placed throughout the kitchen and education provided to kitchen staff for their continued usage. 2. Education was provided to kitchen staff regarding the identified deficient practices and regular corrective education is ongoing as needed. 3. Dining Services Director and/or designee will monitor for effectiveness and report back through our QA process for monthly follow up.	03/07/2023

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	02/06/23 at 9:30 AM, located inside the walk-in refrigerator was two blocks on sliced cheese. The sliced cheese packets were opened and did not document a date the cheese was opened. On 02/06/23 at 9:30 AM, the Dietary Aide confirmed there were two opened blocks of sliced cheese without a date to indicate when the packages were opened and placed in the refrigerator. The Dietary Aide explained all food was to be labeled upon opening to protect the residents from getting sick if consumed. On 02/06/23 at 9:52 AM, the Kitchen Manager confirmed two opened blocks of sliced cheese without a date to indicate when the cheese was opened and verbalized all food was to be labeled with the date opened to prevent any food borne illnesses when served to residents. Expired Food On 02/06/23 at 9:30 AM, located inside the walk-in refrigerator were two blocks of cheddar cheese with a documented date opened of January 5, 2023. On 02/06/23 at 9:30 AM, the Dietary Aide confirmed there were two blocks of expired cheddar cheese, dated January 5, 2023 and verbalized all opened items were to be discarded after five days of opening. On 02/06/23 at 9:52 AM, the Kitchen Manager confirmed there were two blocks of cheddar cheese in the refrigerator with a date of January 5, 2023, and verbalized all food items were to be discarded five days after opening to prevent food borne illnesses. Hairnet Usage On 02/06/23 at 9:22 AM, upon entering the kitchen, there were three staff members without a hairnet present. One staff member was stirring a large pot of soup, the second and third staff member were prepping food at the holding tray station. On 02/06/23 at 9:22 AM, the Dietary Aide confirmed all three staff members were working with food in the kitchen without wearing a hairnet and verbalized staff were to be wearing a hairnet at all times while working with residents food. On 02/06/23 at 9:52 AM, the Kitchen Manager explained all kitchen staff were expected to wear a hairnet at all times		4. Corrected Date: 3/7/2023	

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	while working in the kitchen. Kitchen Aid Mixer On 02/06/23 at 9:26 AM, located at a food preparation station, was a Kitchen Aid Mixer. Inside the bowl, used to mix food, was a pair of gloves and a large stack of papers. On 02/06/23 at 9:26 AM, the Dietary Aid confirmed there was a set of gloves and a large stack of papers located inside of the mixer bowl. The Dietary Aid explained kitchen staff were using the preparation station at the current moment to prepare dessert for residents and the items were not to be in the mixing bowl because items could contaminate appliances used to prepare food for residents. On 02/06/23 at 9:52 AM, the Kitchen Manger verbalized all personal items were not to be stored in appliances in the kitchen or in food preparation areas to prevent bacterial cross contamination from foreign items in the kitchen to food served to residents. Quat Buckets On 02/06/23 at 9:35 AM, during a tour of the kitchen, no quat buckets could be located in any section of the kitchen. On 02/06/23 at 9:35 AM, the Dietary Aide confirmed there were no quat buckets in the kitchen and explained a sanitizing solution was mixed and poured into quat buckets to sanitize the kitchen after each meal service. The Dietary Aide verbalized all quat buckets had been missing from the kitchen since the previous day and no one was able to explain where the quat buckets went. On 02/06/23 at 9:52 AM, the Kitchen Manager confirmed the kitchen did not have quat buckets in the kitchen since the previous day and could not verify how the kitchen was being sanitized after each meal service. The Kitchen Manager explained quat buckets were to be in the kitchen at all times with the sanitizing solution ready for disinfecting the kitchen. If the kitchen was not sanitized properly, bacteria could start to grow on surfaces in the kitchen and cross contaminate all food served to residents. Severity: 2 Scope: 3			

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0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on record review and interview, the facility failed to ensure employees obtained timely first aid and cardiopulmonary resuscitation (CPR) training for 2 of 13 sampled employees working at the facility greater than 30 days (Employee #1 and #13). Findings include: On 02/06/23, the Admissions and Office Manager was provided the Personnel Check List to complete for 14 sampled employees. On 02/07/23, the Admissions and Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Executive Director with a start date of 10/04/22. Employee #1's employee file contained a first aid and CPR training certificate dated 12/07/22. Employee #13 Employee #13 was hired by the facility as Resident Aide with a start date of 01/05/23. Employee #13's employee file lacked a first aid and CPR training certificate. On 02/06/23 at 3:33 PM, the Administrator provided the Attestation of Compliance form, signed, and dated 02/06/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0450	1. Employee #1 CPR was completed outside of time requirements. Employee #13 has been enrolled in CPR and first aid class and will be completed. 2. The facility will complete an audit of all employee files to ensure all applicable staff members have completed their First Aid & CPR training within 30 days of employment. 3. The Administartor will review findings of the audit and report effectiveness of plan to complete First Aid & CPR training within 30 days of employment. 4. Corrected Date: 3/7/2023	03/07/2023
0620	Written Policy on Admissions - NAC	0620	1. Resident #3, #6, #8, #9, #10, #13, #14,	03/13/202

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SS= F	449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 26 of 26 residents receiving skilled nursing services (Resident #3, #6, #8, #9, #10, #13, #14, #16, #17, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40). Findings include: Resident #3 Resident #3 was admitted to the facility on 01/29/21, with a diagnosis of degenerative joint disease. Resident #6 Resident #6 was admitted to the facility on 02/02/22, with a diagnosis of dementia. Resident #8 Resident #8 was admitted to the facility on 07/12/22, with a diagnosis of benign prostatic hyperplasia. Resident #9 Resident #9 was admitted to the facility on 01/16/23, with a diagnosis of hypothyroidism. Resident #10 Resident #10 was admitted to the facility on 07/12/22, with a diagnosis of thromboembolism secondary to atrial fibrillation. Resident #13 Resident #13 was admitted to the facility on 09/12/22, with a diagnosis of irritable bowel syndrome. Resident #14 Resident #14 was admitted to the facility on 08/14/22, with a diagnosis of memory loss. Resident #16 Resident #16 was admitted to the facility on 10/05/22, with a diagnosis of impaired memory. Resident #17 Resident #17 was admitted to the facility on 01/31/19, with a diagnosis of anxiety disorder. Resident #24 Resident #24 was admitted to the facility on 02/01/23, with a diagnosis of congestive heart failure. Resident #25 Resident #25 was admitted to the facility on 01/28/20, with		#16, #17, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35,#36, #37, #38, #39, #40 have all had a waiver submitted for admission or continued stay at the facility. 2. Education has been provided to the Administrator and Wellness Director by Director Operations from Mission Senior Living. 3. The Administrator and Administrative Wellness staff will audit resident charts for waiver needs for any residents meeting the criteria, once a month and report findings through our QA process. 4. Corrected Date: 3/7/2023	3

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	a diagnosis of neuropathy. Resident #26 Resident #26 was admitted to the facility on 03/24/20, with a diagnosis of macular degeneration. Resident #27 Resident #27 was admitted to the facility on 02/01/22, with a diagnosis of dementia. Resident #28 Resident #28 was admitted to the facility on 02/27/22, with a diagnosis of atrial fibrillation with a pacemaker. Resident #29 Resident #29 was admitted to the facility on 04/27/22, with a diagnosis of dementia. Resident #30 Resident #30 was admitted to the facility on 03/01/22, with a diagnosis of hypothyroidism. Resident #31 Resident #31 was admitted to the facility on 11/19/18, with a diagnosis of hypothyroidism. Resident #32 Resident #32 was admitted to the facility on 12/24/19, with a diagnosis of hypothyroidism. Resident #33 Resident #33 was admitted to the facility on 09/03/21, with a diagnosis of atrial fibrillation. Resident #34 Resident #34 was admitted to the facility on 09/03/21, with a diagnosis of dementia. Resident #35 Resident #35 was admitted to the facility on 10/17/18, with a diagnosis of dementia. Resident #36 Resident #36 was admitted to the facility on 02/13/20, with a diagnosis of dementia. Resident #37 Resident #37 was admitted to the facility on 12/08/21, with a diagnosis of depression. Resident #38 Resident #38 was admitted to the facility on 05/31/22, with a diagnosis of depression. Resident #39 Resident #39 was admitted to the facility on 08/19/16, with a diagnosis of dementia. Resident #40 Resident #40 was admitted to the facility on 03/29/21, with a diagnosis of dementia. On 02/06/23 at 2:25 PM, the Administrator confirmed the facility had residents receiving skilled nursing care through home health and hospice agencies. The Administrator explained the Administrator was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The Administrator confirmed the facility had not submitted waivers to the State Agency to admit or retain residents receiving skilled			

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	nursing care. Severity: 2 Scope: 3			
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 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 his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure a physical examination was completed upon admission for 2 of 25 sampled residents (Resident #19 and #20). Findings include: Resident #19 Resident #19 was admitted to the facility on 09/22/22, with diagnoses including hypothyroidism, hyperlipidemia, and chronic kidney disease. Resident #19's clinical record included a general physical examination completed on 09/27/22. On 02/06//23 at 3:55 PM, the Administrator confirmed the general physical examination for Resident #19 was late and should have been completed on or before the resident's admission to the facility. Resident #20 Resident #20 was admitted to the facility on 11/04/22, with diagnoses including hypertension, neuropathy, and benign prostatic hyperplasia. Resident #20's clinical record contained a History and Physical dated 11/07/22, three days after admission. On 02/06//23 at 3:08 PM, the Administrator confirmed the History and Physical for Resident #20 was late and should have been completed on or before the resident's admission to the facility. Severity: 2 Scope: 1	0859	1. Resident #19 H&P was completed on 10/11/2022 documentation has been added to the chart. Resident #20 H&P date is 11/07/2022 however the resident's physical move in was not until 11/11/2022. 2. Education was provided to Administrator to verfiy accurate move in dates and avoid miscommunication of the move in dates. 3. New admissions documentation will be audited prior to admission to ensure H&P is done timely. 4. Corrected Date: 3/7/2023	03/07/2023
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of	0870	1. Resident #6 was out of facility during that period but has had a pharmacy review	03/07/2023

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	medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on document review, record review and interview, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 2 of 25 sampled residents residing in the facility for longer than six months (Resident #6 and #3). Resident #6 Resident #6 was admitted to the facility on 02/09/22, with diagnoses including dementia, hallucination due to late onset dementia, hypertension and insomnia. Resident #6's clinical record included a medication review completed on 12/08/22. The review was due to be completed no later than 08/09/22, and subsequently every six months. On 02/07/23 at 2:15 PM, the Administrator confirmed the resident file for Resident #6 lacked medication reviews completed prior to 12/08/22. Resident #3 Resident #3 was admitted to the facility on 01/29/21, with		completed. Resident #3 medication reviews prior to 12/08/2022 were found and put in the resident's chart. 2. Wellness administrative staff will perform audits every 6 months to ensure all residents receive a pharmacy review. 3. all Audits will be reviewed for effectiveness and referred to our QA process, for review by the Administrator. 4. Corrected Date: 3/7/2022	

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	diagnoses including essential hypertension, benign and late onset Alzheimer's disease with behavioral disturbance. Resident #3's clinical record included a medication review completed on 12/08/22. The review was due to be completed no later than 07/29/21, and subsequently every six months. On 02/06/23 at 3:58 PM, the Administrator confirmed the resident file for Resident #3 lacked medication reviews completed prior to 12/08/22. Severity: 2 Scope:1			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the physician. If a physician 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 (Previously Y 0879) (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 must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared	0878	1. Resident #24 Hospice delivered the medication to the resident's home, it was brought to the facility to administer according to the physician's orders. 2. Education will be provided to the Wellness Team to ensure all medication will be delivered to the facility upon admission. 3. Audit of new admissions will be completed to ensure all medications with orders are on hand. 4. Corrected Date: 3/7/2023	03/07/2023

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		A. BUILDING _____ B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT ESTATES	**222 EAST PATRIOT BLVD, RENO, NEVADA ,89511**

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	by a pharmacist does not match the order or prescription written by a physician, the 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 clinical record review and interview, the facility failed to ensure medications were on-site to administer as prescribed for 1 of 25 sampled residents (Resident #24). Findings include: Resident #24 Resident #24 was admitted to the facility on 02/01/23, with a diagnoses including heart failure, atrial fibrillation, and hypertension. Resident #24's physician order, dated 01/30/23, documented lorazepam 2 milligrams (mg) per milliliter (ml), take 0.25 ml (0.5 mg) by mouth every four hours as needed for anxiety, agitation and nausea. Resident #24's February 2023 Medication Administration Record (MAR) documented lorazepam 2 mg/ml, take 0.25 ml (0.5 mg) by mouth every four hours as needed for anxiety, agitation and nausea. The resident's medication was not available on site, to be administered as prescribed. On 02/06/23 at 2:15 PM, the Wellness Assistant confirmed the facility lacked Resident #24's PRN lorazepam and would have the resident's family deliver a new bottle. Severity: 2 Scope: 1			
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	0885	1. Resident #6's haloperdiol supply was removed and destroyed. Resident #1's sertraline was removed and destroyed. 2. All wellness staff will be educated on medication destruction policy and process to ensure discontinued medications are destroyed in a timely manner. 3. Wellness administrative staff will conduct an audit daily to ensure all medications that have	03/07/2023

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	in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure a discontinued medication was destroyed and not stored with a resident's current medications for 2 of 25 sampled residents (Residents #6 and #1). Findings include: Resident #6 Resident #6 was admitted to the facility on 02/09/22, with diagnoses including dementia and hypertension. On 02/06/23, during review of the resident's medications a blister card of haloperidol 0.5 mg tablets was in the storage area for Resident #6's medications. On 02/06/23 at 2:50 PM, the Medication Technician (MT) verbalized the haloperidol had been discontinued and discontinued medications were supposed to be destroyed when they were discontinued. An order dated 01/31/23, documented to discontinue the haloperidol. Resident #1 Resident #1 was admitted to the facility on 06/03/22, with diagnoses including hypertension, depression, and atrial fibrillation. On 02/06/23, during review of the resident's medications a bottle of sertraline 50 milligram (mg) tablets with an expiration date of 01/18/23, was in the storage area for Resident #1's medications. On 02/06/23 at 3:06 PM, the MT verbalized there was not an active order for the sertraline and the medication should not have been stored with the resident's active medications. An order dated 01/27/23, documented to discontinue the sertraline. The facility policy titled "Medication Disposal," dated 03/2018, documented the facility would establish practices for return/destruction/disposal of expired or discontinued medications. Severity: 2 Scope: 1		been discontinued have been removed and destroyed. 4. Corrected Date: 3/7/2023	
0936 SS= E	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	0936	1. Resident # 7 TB Test was administered past the required time but was administered. Resident #9 second step of tb test was administered by staff. Resident #19 appropriate	03/07/2023

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	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure 7 of 25 sampled residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #7, #9, #19, #6, #13, #1, and #8). Findings include: Resident #7 Resident #7 was admitted to the facility on 09/06/22 with diagnoses including hyperthyroidism, hypertension and diabetes mellitus. Resident #7's first-step TB test was given on 09/14/22 and read negative on 09/16/22. The test was administered eight days after admission. On 02/06/23 at 4:03 PM, the Wellness Assistant confirm the test was administered eight days after admission and verbalized the facility had seven days to administer the first-step TB test. NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation in medical record. (Nevada Revised Statute (NRS) 439.200, 441A.120). (2) There is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever		documentation was acquired form the administering community. Resident #6 tb test was readministered by staff. Resident #13 appropriate documentation was acquired from the administering facility. Resident #1 appropriate documentation was acquired from the administering facility. Resident #8 Wellness Director has completed the sign and symptoms checklist 2. The Wellness administrative team will conduct an audit of all resident records to ensure TB test are completed with complete documentation in the residents charts. 3. The Wellness Director will complete a monthly audit to ensure all TB Tests are done timely and documented appropriately. 4. Corrected Date: 3/7/2023	

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	is sooner. Resident #9 Resident #9 was admitted to the facility on 01/16/23, with diagnoses including hypothyroidism, compression fractures, and influenza. The clinical record for Resident #9 lacked a TB test. Resident #19 Resident #19 was admitted to the facility on 09/22/22, with diagnoses including hypothyroidism, hyperlipidemia, and chronic kidney disease. The clinical record for Resident #19 included an undated TB test. On 02/06/23 at 4:02 PM, the Administrator confirmed the clinical record for Resident #9 lacked a TB test and the clinical record for Resident #19 included a TB test with no date to determine when the test results were read. Resident #6 Resident #6 was admitted to the facility on 02/09/22. with diagnoses including dementia, hallucination due to late onset dementia, hypertension and insomnia. Resident #6's first-step was administered on 02/16/22 and read on 02/21/22. The second step was administered on 02/25/22 and read on 02/28/22. The TB test administered was seven days after admission and had more than 72 hours between the date administered and the date read on the first-step TB test. On 02/06/23 at 2:15 PM, the Administrator confirmed Resident #6's TB test was late and the first-step was invalid. The Administrator explained no more than 72 hours can lapse after administration of TB and reading the TB results. The Administrator verbalized the initial TB test for Resident #6 was invalid. Resident #13 Resident #13 was admitted to the facility on 09/12/22, with diagnoses including arthritis and irritable bowel syndrome. Resident #13's initial TB test was administered on 09/28/22 and lacked a read date. The second-step was administered on 10/05/22 and lacked a read date. Resident #13's clinical file documented a second two-step TB test administered on 11/04/22 and read on 11/07/22. The second-step was administered on 11/11/22 and read on 11/14/22, two months after admission to the facility. On 02/06/23 at 2:15 PM, the			

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	Administrator confirmed the initial two-step TB test was invalid and did not document read dates and confirmed the second two-step TB test was late, two months after the resident admitted to the facility. The Administrator explained all residents TB tests were to be completed upon admission and annually thereafter. Resident #1 Resident #1 was admitted to the facility on 06/03/22, with diagnoses including depression, atrial fibrillation, and hypertension. Resident #1's initial TB test was administered on 01/20/22 and lacked a read date. The second step was administered on 01/23/22, and lacked a read date. On 02/06/23 at 2:51 PM, the Administrator verbalized the TB tests for Resident #1 did not contain read dates and were invalid. Resident #8 Resident #8 was admitted to the facility on 07/22/22, with diagnoses including vascular dementia with anxiety and hypertension. Resident #8's initial TB test was administered 07/26/22 and read on 07/28/22. The second step was administered on 08/05/22 and read on 08/08/22. The resident's clinical record lacked the signs and symptoms of TB. On 02/06/23 at 2:55 PM, the Administrator confirmed the TB tests for Resident #8 lacked the signs and symptoms questionnaire for TB. Severity: 2 Scope: 2			
0938 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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any	0938	1. Resident #20 Physical move in was 11/11/22. Resident #23 was finalized by staff outside of compliance window. Administrator is in place and no longer is an issue. 2. The Wellness Administrative Team will conduct an audit of all residents charts to ensure all required assessments are contained in the resident charts. 3. The Wellness Administrative Team will conduct monthly audits to ensure continued compliance with assessment requirements. 4. Corrected Date: 3/7/2023	03/07/2023

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	assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure Activities of Daily Living (ADL) Assessments were completed upon admission for 2 of 25 sampled residents (Resident #20 and #23). Resident #20 Resident #20 was admitted to the facility on 11/04/22, with diagnoses including hypertension, neuropathy, and benign prostatic hyperplasia. Resident #20's clinical record contained an initial ADL Assessment dated 11/11/22, seven days after admission. On 02/06/23 at 3:08 PM, the Administrator confirmed the ADL Assessment was completed late for Resident #20. Resident #23 Resident #23 was admitted to the facility on 10/12/22, with diagnoses including dementia, hypothyroid, and iron deficient anemia. Resident #23's clinical record contained an initial ADL Assessment dated 10/27/22, nine days after admission. On 02/06/23 at 3:10 PM, the Administrator confirmed the ADL Assessment was completed late for Resident #23. Severity: 2 Scope: 1			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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0945 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) 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the Bureau who is acting in his or her capacity as an employee of the Bureau. Inspector Comments: Based on observation and interview, the facility failed to keep medical information of the residents confidential. Findings include: On 02/06/23 at 4:26 PM, there was a computer on a medication card with visible information clearly exposed on the screen. The Medication Technician was not in the area at the time of discovery. After approximately two minutes, the Medication Technician was observed walking from the common dining area toward the medication cart. The Medication Technician verbalized the computer was to be locked to prevent resident information from being visible to other residents and the public every time the Medication Technician walked away from the medication cart. The Medication Technician confirmed the resident information was left unlocked on the computer screen and acknowledged the exposed information was a Health Insurance Portability and Accountability Act (HIPAA) violation. On 02/06/23 at 4:33 PM, the Administrator explained all computers were to be locked when Medication Technicians walked away from the computer to avoid personal information for residents from being exposed to other residents or the public. Severity: 2 Scope: 1	0945	1. Employee was given direction immediately to lock the computer screen whenever they are not attending to it. 2. Education provided to all medication administering to staff to lock the computer screen and to protect resident information. 3. Wellness administrative staff will conduct observations once a week to ensure staff are following procedure and taking appropriate precaution to protect PHI. 4. Corrected Date: 3/7/2023	03/07/2023
0966 SS= F	Alzheimer’s Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 5. The	0966	1. All staffing efforts to continue to be a main priority. While managing recruitment retention and staff management efforts staffing has	03/07/2023

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	administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on interview and document review, the facility failed to ensure there was staffing of one Caregiver for every six residents during residents' waking hours in an Alzheimer's endorsed facility. Findings include: Review of the December 2022 and January 2023 staffing schedule documented the following dates and times the facility was not providing one caregiver to six residents who resided in the facility which was endorsed for Alzheimer's Disease. The census for December 2022 was 26 or more each day of the month, requiring 5 staff members during resident waking hours. Staffing was not met on the following dates during the noted hours: - 12/01/22 between the hours of 2:00 PM to 7:00 PM - 12/02/22 between the hours of 2:00 PM to 7:00 PM - 12/03/22 between the hours of 4:30 PM to 7:00 PM - 12/04/22 between the hours of 6:00 PM to 7:00 PM - 12/05/22 between the hours of 3:30 PM to 7:00 PM - 12/06/22 between the hours of 2:00 PM to 7:00 PM - 12/07/22 between the hours of 2:00 PM to 7:00 PM - 12/08/22 between the hours of 4:00 PM to 6:00 PM - 12/09/22 between the hours of 2:00 PM to 7:00 PM - 12/10/22 between the hours of 2:00 PM to 7:00 PM - 12/11/22 between the hours of 2:00 PM to 7:00 PM - 12/12/22 between the hours of 2:00 PM to 3:30 PM and 5:00 PM to 7:00 PM - 12/13/22 between the hours of 2:00 PM to 6:00 PM - 12/14/22 between the hours of 6:00 AM to 2:00 PM and 5:00 PM to 7:00 PM - 12/15/22 between the hours of 2:00 PM to 7:00 PM - 12/16/22 between the hours of 2:00 PM to 7:00 PM - 12/17/22 between the hours of 2:00 PM to 7:00 PM - 12/18/22 between the hours of		been more consistent. 2. The Administrator will audit of all scheduling for memory care staffing to ensure proper levels are maintained during waking hours. 3. Wellness Administrative staff will continue to staff according to regulations whenevr possible. 4. Corrected Date: 3/7/2023	

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	2:00 PM to 7:00 PM - 12/19/22 between the hours of 2:00 PM to 7:00 PM - 12/20/22 between the hours of 5:00 PM to 7:00 PM - 12/21/22 between the hours of 5:00 PM to 7:00 PM - 12/22/22 between the hours of 2:00 PM to 7:00 PM - 12/23/22 between the hours of 6:00 AM to 2:00 PM and 5:00 PM to 7:00 PM - 12/24/22 between the hours of 6:00 AM to 12:00 PM and 2:00 PM to 7:00 PM - 12/25/22 between the hours of 6:00 AM to 2:00 PM and 5:00 PM to 7:00 PM - 12/27/22 between the hours of 5:00 PM to 7:00 PM - 12/28/22 between the hours of 2:00 PM to 7:00 PM - 12/29/22 between the hours of 2:00 PM to 7:00 PM - 12/30/22 between the hours of 2:00 PM to 7:00 PM - 12/31/22 between the hours of 3:00 PM to 7:00 PM The census for Jan 1 through 11 and 13 through 16, 2023 was 20 to 24, requiring 4 staff members during resident waking hours. Staffing was not met on the following dates during the noted hours: - 01/01/23 between the hours of 6:00 AM to 7:00 PM - 01/02/23 between the hours of 5:00 PM to 7:00 PM - 01/03/23 between the hours of 3:00 PM to 7:00 PM - 01/04/23 between the hours of 3:00 PM to 7:00 PM - 01/05/23 between the hours of 3:00 PM to 7:00 PM - 01/07/23 between the hours of 2:00 PM to 7:00 PM - 01/08/23 between the hours of 5:00 PM to 7:00 PM - 01/09/23 between the hours of 5:00 PM to 7:00 PM - 01/10/23 between the hours of 2:00 PM to 7:00 PM The census for Jan 12 and 17 through 30, 2023 was 25 or greater, requiring 5 staff members during resident waking hours. Staffing was not met on the following dates during the noted hours: - 01/12/23 between the hours of 6:00 AM to 10:00 AM and 2:00 PM to 7:00 PM - 01/17/23 between the hours of 5:00 PM to 7:00 PM - 01/19/23 between the hours of 6:00 AM to 9:00 AM - 01/20/23 between the hours of 6:00 PM to 7:00 PM - 01/21/23 between the hours of 5:00 PM to 7:00 PM - 01/22/23 between the hours of 6:00 AM to 2:00 PM - 01/23/23 between the hours of 5:00 PM to 7:00 PM - 01/24/23 between the			

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	hours of 5:00 PM to 7:00 PM - 01/25/23 between the hours of 5:00 PM to 7:00 PM - 01/26/23 between the hours of 6:00 AM to 7:00 PM - 01/29/23 between the hours of 2:00 PM to 7:00 PM On 02/06/23 at 12:09 PM, the Administrator verbalized and agreed 6:00 AM to 7:00 PM would be used to determine resident waking hours in the memory care unit. The Administrator verbalized the facility was understaffed when hired as the Administrator. The Administrator confirmed there were gaps in the schedule and the facility was not meeting the one staff member to six resident ratio for the months of December 2022 and January 2023 on various shifts. Complaint #NV00067601 and #NV00067556 Severity: 2 Scope: 3			
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 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 and interview, the facility failed to ensure dangerous items were inaccessible to residents housed in the memory care unit. Findings include: On 02/06/23, the following resident rooms and common areas in the memory care unit were found to contain unsecured, dangerous items: : At 09:59 AM, Room 16A contained: - a razor was located on the nightstand At 10:05 AM, Room 15B contained: - a corkboard with six push pins - a corkboard with two push pins - a corkboard with five push pins At 10:23 AM, Room 14B contained a space heater. At 10:29 AM, Room 11B contained a wall had two push pins. At 10:43 AM, Room 8B contained a space heater was in the	0994	1. All dangerous items were removed from the memory care unit and a letter was sent to all family members to not bring in these items as they are not permitted. 2. Education provided by the Wellnes Director to perform every shift checks by staff. Residents' families were also provided education. 3. Wellness Director or designee will perform random daily audits of three resident rooms to ensure checks are being competed. 4. Corrected Date: 3/7/2023	03/07/2023

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		A. BUILDING _____ B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT ESTATES	**222 EAST PATRIOT BLVD, RENO, NEVADA ,89511**

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	resident's closet. At 10:48 AM, Room 9A contained a jar containing small beads. At 10:50 AM, an electrical face plate with two small screws were on a counter in the common area, accessible to all residents in the memory care unit. At 10:56 AM, Room 8A contained a bag of Chinese checker balls. At 12:15 PM, Room 7A contained: - a heating pad - a wall had one push pin At 10:14 AM, Room 14A contained two push pins on a wall. At 10:38 AM, Room 10A contained two push pins on a wall. At 10:56 AM, Room 8A contained a safety pin. At 12:27 PM, Room 4A contained umbrella toothpicks. On 02/06/23 at 09:59 AM through 12:30 PM, the Director of Environmental Services confirmed the items found were dangerous and should be secured. On 02/06/23 at 4:30 PM, the Administrator verbalized the facility did not have a policy on dangerous items in the memory care unit. Severity: 2 Scope: 3			
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure toxic items were secured in resident rooms and common areas in the memory care unit. Findings include: On 02/06/23 the following resident rooms in the memory care unit were found to contain unsecured and toxic substances: At 9:44 AM, the bathroom in room 17B had: -one 3.2-ounce (oz) tube of Colgate optic white toothpaste -one 2.4 oz tube of Polygrip denture adhesive -23 tablets of denture cleanser -one Ricola cough drop At 9:49 AM, room 18A had one travel size tube of Colgate total toothpaste.	0999	1. All toxic substances were removed from the residents' rooms immediately. 2. Wellness staff will perform room audits every shift to ensure no toxic substances are available to residents. 3. Education provide to residents' family members and staff to not bring or allow toxic substances in the room. 4. Corrected Date: 3/7/2023	03/07/2023

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	At 9:52 AM, room 17A had one 2.7 oz tube of Degree advanced deodorant. At 9:54 AM, room 18B had one 8.2 oz. tube of Crest complete with Scope toothpaste. At 9:59 AM, room 16A had one Ricola cough drop. At 10:14 AM, the bathroom of room 14A had: -one 5.5 oz. tube of Tom's original toothpaste -one 4.8 oz. tube of Colgate total care toothpaste -one 0.8 oz tube of Sensodyne toothpaste -one tube of Tom's wild lavender deodorant At 10:24 AM, room 14B had ten 0.33 oz, bottles of essential oils. At 10:38 AM, room 10A had one case containing 30 bottles of Ensure original nutrition shakes. At 10:46 AM, room 8B had one 15-gram bottle of Nystop powder. At 10:49 AM, room 9A had one tube of Crest pro-health advanced toothpaste. At 11:04 AM, the bathroom between rooms 7A and 7B had one bar of pink soap. At 11:55 AM, room 2A had one 4 oz. tube of Arbonne hand cream. At 12:03 PM, room 5A had: -one 7 oz. tube of Medline soothe and cool moisture barrier ointment, labeled keep out of reach of children. -eight 8 oz. tubes of Remedy body lotion, labeled with warning to avoid eye contact. -six 4 oz. tubes of intensive skin therapy with dimethicone cream, -one tube of Coloplast moisture barrier cream with zinc oxide, and -one open medication cup containing a clear gel like substance, unlabeled and in a torn plastic bag. At 12:20 PM, room 7A had one 6.7 oz. bottle of screen cleaning gel for electronics. At 10:05 AM, room 15B had one travel size tube of Colgate Cavity Protection toothpaste. At 10:19 AM, room 12 had one 4.8-ounce tube of Colgate adult toothpaste. At 10:23 AM, the bathroom in room 14B had: - a Germ-X soft wipe - a container of Vagisil Anti-Itch At 10:56 AM, room 8A had one Febreze plug-in air freshener. At 11:06 AM, room 7B had one Mucinex sore throat drop. At 12:34 PM, room 2A had one Airwick plug-in air freshener. At 12:35 PM, one plug-in air freshener was located in the corridor between room 1A and room 1B. On 02/06/23 at 12:34 PM, the Director of			

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	Environmental Services confirmed the potentially toxic items should have been removed and/or secured. On 02/06/23 at 4:30 PM, the Administrator verbalized the facility did not have a policy on toxic items in the memory care unit. Severity: 2 Scope: 3			
1310 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.] 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. (Added to NRS by 2019, 1333, effective January 1, 2020) Inspector Comments: Based on observation and interview, the facility failed to post prominently in the facility the State contact information to file a complaint for a resident who may have experienced prohibited discrimination. Findings include: On	1310	1. The Posting was replaced with a posting that contains the contact information to file a complaint of discrimination. 2. No further action is required for this deficient practice as the posting was corrected. 3. Corrected date: 02/10/2023	02/10/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	02/06/23 at 09:21 AM, the facility lacked posted documentation of the State contact information to file a complaint for any resident who may experience discrimination. On 02/06/23 at 09:21 AM, the Director of Environmental Services acknowledged the State's contact information had not been posted in any common public area of the facility to inform residents where to file a complaint of discrimination. Severity: 1 Scope: 3			
1540 SS= E	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. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure employees had completed a cultural competency course approved by the Division of Public and Behavioral Health for 5 of 13 employees (Employees #1, #5, #12, #13, and #14). Findings include: On 02/06/23, the Admissions and Office Manager was provided the Personnel Check List to complete for 14 sampled employees. On 02/07/23, the Admissions and Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired as the	1540	1. Cultural competency training was provided for all staff members found to not have completed at the next training provided by the association, which was 2/25/23 2. the facility administrative assistant performed an audit of all employee files to ensure all staff have received the training. 3. New employee audits will be performed by the administrative assistant to ensure continued compliance with the training. 4. Corrected Date: 3/31/2023	03/31/2023

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	Executive Director with a start date of 10/04/22. The personnel record for Employee #1 lacked documented evidence the employee had completed a cultural competency course. Employee #5 Employee #5 was hired as a Resident Aide with a start date of 08/09/22. The personnel record for Employee #5 lacked documented evidence the employee had completed a cultural competency course. Employee #12 Employee #12 was hired as a Medication Technician with a start date of 11/15/17. The personnel record for Employee #12 contained a cultural competency training certificate dated 08/18/22. Employee #13 Employee #13 was hired as a Resident Aide with a start date of 01/05/23. The personnel record for Employee #13 lacked documented evidence the employee had completed a cultural competency course. Employee #14 Employee #14 was hired as a Resident Aide with a start date of 12/29/22. The personnel record for Employee #14 lacked documented evidence the employee had completed a cultural competency course. On 02/06/23 at 3:33 PM, the Administrator provided the Attestation of Compliance form, signed, and dated 02/06/23, confirming the Admissions and Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2			
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;	1700	1. All residents have been assessed and written assessment has been placed in each chart to certify appropriate placement within the community. 2. Education was provided to Administrator of requirement and importance of continued compliance to placement requirements with assessment. 3. The Wellness Director will perform an	03/07/2023

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	(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 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 record review and interview, the facility failed to obtain a complete and accurate Standard Physician Assessment and Placement		audit annually and report findings to the Administrator to ensure appropriate placement of each resident. 4. Corrected Date: 3/7/2023	

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	Determination for 3 of 25 residents (Resident #5, #18 and #1). Findings include: Resident #5 Resident #5 was admitted to the facility on 03/05/21, with diagnoses including dementia, anxiety, and coronary artery disease. Resident #5's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 02/06/23 at 3:59 PM, the Wellness Assistant confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #5. Resident #18 Resident #18 was admitted to the facility on 01/26/21 with diagnoses including coronary heart failure, cardiomyopathy, and diabetes type II. Resident #18's clinical record contained an undated statement from the physician documenting the resident had a diagnosis of dementia, Alzheimer's or cognitive impairment and was appropriate for to reside in a non-secured Assisted Living community. On 02/06/23 at 3:05 PM, the Administrator confirmed the statement was undated and not valid for Resident #18. Resident #1 Resident #1 was admitted to the facility on 06/23/22 with diagnoses including depression, atrial fibrillation, and hypertension. Resident #1's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 02/06/23 at 2:51 PM, the Administrator confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #1. Severity: 2 Scope: 1			