STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11715	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN NEVADA STATE VETERANS HOME	36 BATTLE BORN WY, SPARKS, NEVADA ,89431

(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 the result of a State Licensure Survey completed in conjunction with a Federal Recertification survey from March 10, 2025 through March 13, 2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Skilled Nursing Facilities. The census was 92. The sample size was 20 employees. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims from relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
342 SS= F	NAC 449.74511 - Personnel Records - Licenses, TB, Background - 3. A current and accurate personnel record for each employee of the facility must be maintained at the facility. The record must include, without limitation: (a) Evidence that the employee has obtained any license, certificate or registration and possesses the experience and qualifications, required for the position held by the employee; (b) Such health records as are required by chapter 441A of NAC which include evidence that the employee has had a skin test for tuberculosis in accordance with NAC 441A.375; and (c) Documentation that the facility has not received any information that the employee has been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.174. Inspector Comments: Based on personnel record review, document review, and interview, the facility failed to ensure 1) initial tuberculosis (TB) was completed timely for 5 of 20 sampled employees (Employee #1, #3, #8, #9, and #10), and physical examinations were completed timely for 2 of 20 sampled employees (Employees #4, and #10) in accordance with Nevada Administrative Code (NAC) 441A.375, and 2) fingerprinting and a Nevada Automated Background System	342	**1.** No residents were identified as affected, though all residents have the potential to be affected by the practice. Employees # 4 and 10's physical evaluations were completed by the medical director. Employees # 7, 21, 22, 23, 24, 25,26, 27, 28, and 29's fingerprints and backgrounds checks were submitted. Employees #1, #3, #8, #9, and #10TB records were reviewed, corrected and current. Facility wide audit of all staff files was completed to ensure TB testing, physical evaluations, and background checks are completed timely and up to date. Staff without current documentation will be removed from the schedule until their records are updated. The People Culture Director will oversee this process and ensure all necessary documents are obtained **2.**	06/06/2025

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	(NABS) clearance was completed under the current facility license for 10 of 30 sampled employees reviewed for fingerprints and background checks (Employees #7, #21, #22, #23, #24, #25, #26, #27, #28, and #29) per Nevada Revised Statutes (NRS) 449.124. The deficient practice placed residents at risk for receiving care from employees not completing all eligibility requirements prior to working with residents. Findings include: TB Testing Employee #1 Employee #1 was hired as the Executive Director with a start date of 09/03/2024. Employee #1's personnel record documented a QuantiFERON TB test completed on 09/13/2024, 10 days late. Employee #3 Employee #3 was hired as the Volunteer Services Director with a start date of 08/01/2024. Employee #3's personnel record documented a on step TB test read negative on 04/21/2023. Employee #3's personnel record lacked documented evidence of a TB completed in 2024. Employee #8 Employee #8 was hired as a Certified Nursing Assistant (CNA) with a start date of 08/02/2024. Employee #8's personnel record lacked documented evidence of a TB test completed in 2024. Employee #9 Employee #9 was hired as a Housekeeper with a start date of 08/01/2024. Employee #9's personnel record lacked documented evidence of a TB test completed in 2024. Employee #10 Employee #10 was hired as a Speech Language Pathologist with a start date of 08/01/2024. Employee #10's personnel record lacked documented evidence of a TB test completed in 2024. On 03/12/2025 at 12:35 PM, during an interview for review of personnel records, the Human Resources Director (HRD) verbalized TB tests were required for all employees prior to the start of work with residents in the facility and annually. The HRD confirmed Employee #1, #3, #8, #9, and #10's personnel file lacked an initial TB test completed upon hire. The facility policy titled "Mantoux/Tuberculosis Testing," dated July 2021, documented Human Resources or designated individual would use the two step TB scheduling to ensure new hires' test are completed timely and complied with all applicable federal, state, and local laws. Physical Examination		No residents were identified as being impacted. Facility implemented a monthly review procedure of all staff compliance documentation, including TB testing, physicals, and background checks. Additionally, updated new hire onboarding processes have been implemented to ensure timely compliance, including a reminder system for these requirements. People Culture Director and Staff Development Coordinator were reeducated on the Personnel Records Policy to ensure continued compliance. Facility has implemented a revised Tracking System to monitor TB testing, physical evaluations, and background checks for all staff. People Culture Director will promptly notify staff and supervisors of upcoming expirations. **3.** The People Culture Director will perform weekly audits x 4 weeks, then monthly audits x 2 months to ensure compliance. Audits will be reviewed in the Monthly QAPI meeting x 3 months or until 100% compliance is achieved. **4. Individual Responsible:** Administrator **5. Date of Completion:** June 6, 2025	

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	Employee #4 Employee #4 was hired as the Registered Dietitian with a start date of 08/01/2204. Employee #4's personnel record laced documented evidence of a physical examination completed upon hire. Employee #10 Employee #10 was hired as a Speech Language Pathologist with a start date of 08/01/2024. Employee #10's personnel record lacked documented evidence of a physical examination completed upon hire. On 03/12/2025 at 12:00 PM, during an interview for review of personnel records, the Human Resources Director (HRD) verbalized physical examinations were required for all employees prior to starting on the floor. The HRD confirmed Employee #4, and #10's personnel record lacked physical examination. Background Check Employee The following employee's lacked fingerprinting and current NABS clearances: - Employee #7 was hired as a CNA with a start date of 08/01/2024. - Employee #21 was hired as a RN with a start date of 08/01/2024. - Employee #22 was hired as Culinary Staff with a start date of 08/01/2024. - Employee #23 was hired as a CNA with a start date of 08/01/2024. - Employee #24 was hired as a CNA with a start date of 08/01/2024. - Employee #25 was hired as the Admissions Director with a start date of 08/01/2024. - Employee #26 was hired as Activities Staff with a start date of 08/01/2024. - Employee #27 was hired as an RN with a start date of 08/01/2024. - Employee #28 was hired as Laundry Staff with a start date of 08/01/2024. - Employee #29 was hired as a Physical Therapy Aide with a start date of 08/01/2024. On 03/11/2025 at 2:45 PM, the facility's NABS report lacked clearance for Employees #7, #21, #22, #23, #24, #25, #26, #27, #28, and #29. On 03/12/2025 at 12:00 PM, during an interview for review of personnel records, the Human Resources Director (HRD) verbalized NABS background checks were required to be completed within 10 days of hire and entered under the current facility license number. The HRD confirmed Employees #7, #21, #22, #23, #24, #25, #26, #27, #28, and #29 did not have background checks completed under the current facility license number. Severity: 2			

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	Scope: 3			
393 SS= F	Personnel Training in Dementia - NAC 449.74522 Employees of facility which provides care to persons with dementia. 1. Except as otherwise provided in subsection 4, each person who is employed by a facility for skilled nursing which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, who has direct contact with and provides care to persons with any form of dementia and who is licensed or certified by an occupational licensing board must complete the following number of hours of continuing education specifically related to dementia: (a) In his first year of employment with a facility for skilled nursing, 8 hours which must be completed within the first 30 days after the employee begins employment; and (b) For every year after the first year of employment, 3 hours which must be completed on or before the anniversary date of the first day of employment. 2. The hours of continuing education required to be completed pursuant to this section: (a) Must be approved by the occupational licensing board which licensed or certified the person completing the continuing education; and (b) May be used to satisfy any continuing education requirements of an occupational licensing board and do not constitute additional hours or units of required continuing education. 3. Each facility for skilled nursing shall maintain proof of completion of the hours of continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete continuing education pursuant to this section. 4. A person employed by a facility for skilled nursing which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, is not required to complete the hours of continuing education specifically related to dementia required pursuant to subsection 1 if he has completed that training within the previous 12 months. 5. As used in this section, " continuing education specifically related to dementia " includes, without limitation,	393	**1.** No residents were identified as affected, though all residents have the potential to be affected by the practice. Employees # 1, 3, 4, 5, 6, 7, 9,10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 have completed the required Dementia Training. All employee records were audited to confirm compliance with the required Dementia Training, and any issues identified will be promptly addressed. **2.** People Culture Director and the Staff Development Coordinator are reeducated on the Dementia Training requirement. The facility implemented a revised Tracking System to ensure all staff have completed the Dementia Training upon hire and at least annually thereafter. Facility implemented a monthly review procedure on all staff compliance with the Dementia Training requirement, to include the new hires. Additionally, updated new hire onboarding processes have been implemented to ensure timely compliance, including a reminder system for these requirements. **3.** People Culture Director will perform weekly audits x 4 weeks, then monthly audits x 2 months will be conducted to ensure compliance. Audits will be reviewed in the Monthly QAPI meeting x 3 months or until 100% compliance is achieved. **4.** Administrator **5.**	06/06/2025

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	instruction regarding: (a) An overview of the disease of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, which includes instruction on the symptoms, prognosis and treatment of the disease; (b) Communicating with a person with dementia; (c) Providing personal care to a person with dementia; (d) Recreational and social activities for a person with dementia; (e) Aggressive and other difficult behaviors of a person with dementia; and (f) Advising family members of a person with dementia concerning interaction with the person with dementia. Inspector Comments: Based on personnel record review, interview and document review, the facility failed to ensure eight hours of dementia training was completed by staff within 30 days of hire for 18 of 20 sampled employees (Employee #1, #3, #4, #5, #6, #7, #9, #10, #11, #12 ,#13, #14, #15, #16, #17, #18, #19, #20) in accordance with Nevada Administrative Code (NAC) 449.74522. The deficient practice placed residents at risk for receiving care from employees not completing all eligibility requirements prior to working with residents. Findings include: The following employees' personnel file lacked documented evidence of eight hours of initial dementia training within 30 days of hire: - Employee #1 was hired by the facility as the Executive Director with a start date of 09/03/2024. - Employee #3 was hired by the facility as the Volunteer Services Coordinator with a start date of 08/01/2024. - Employee #4 was hired by the facility as the Registered Dietitian with a start date of 08/01/2024. - Employee #5 was hired by the facility as the Social Services Director with a start date of 01/07/2025. - Employee #6 was hired by the facility as the Nutrition Services Director with a start date of 08/01/2024. - Employee #7 was hired by the facility as a Certified Nursing Assistant (CNA) with a start date of 08/01/2024. - Employee #9 was hired by the facility as a Housekeeper with a start date of 08/01/2024. - Employee #10 was hired by the facility as a Speech Language Pathologist with a start date of 08/01/2024. - Employee #11 was hired by the facility as an Agency Registered Nurse		June 6, 2025	

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	(RN) with a start date of 08/01/2024 and as a facility RN on 01/28/2025. - Employee #12 was hired by the facility as an RN/Infection Preventionist with a start date of 08/01/2024. - Employee #13 was hired by the facility as an RN with a start date of 08/01/2024. - Employee #14 was hired as a License Practical Nurse (LPN) with a start date of 08/27/2024. - Employee #15 was hired as an LPN with a start date of 09/03/2024. - Employee #16 was hired as a CNA with a start date of 08/01/2024. - Employee #17 was hired as a CNA with a start date of 08/01/2024. - Employee #18 was hired as Culinary Staff with a start date of 01/28/2025. - Employee #19 was hired as Culinary Staff with a start date of 10/08/2024. - Employee #20 was hired as a Housekeeper with a start date of 10/08/2024. On 03/12/2025 at 2:00 PM, the Human Resources Director (HRD) verbalized all staff were required to take dementia training upon hire and confirmed Employee #1, #3, #4, #5, #6, #7, #9, #10, #11, #12 ,#13, #14, #15, #16, #17, #18, #19, #20 did not receive the required eight hours of dementia training within 30 days of hire. The facility policy titled "Staff Competencies," last revised July 2021, documented the facility would ensure staff had the appropriate competencies and skill sets to provide nursing, food, nutrition, and related services to assure resident safety and attain or maintain the highest practical physical, mental, and psycho-social well-being of each resident. Severity: 2 Scope: 3			

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530 SS= C	CMS star rating posting - 2. A medical facility or facility for the dependent that receives a star rating from the Centers for Medicare and Medicaid Services shall post the most recent star rating assigned to the facility in a conspicuous place near each entrance to the facility that is regularly used by the public and, if the facility maintains an Internet website that is accessible to the public, on that Internet website. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility's Centers for Medicare and Medicaid Services (CMS) star rating was posted in a conspicuous place in the facility and on the facility's Internet website per Nevada Revised Statutes (NRS) 449.1825. Findings include: On 03/12/2025 during the morning, the facility's posted star rating on the facility's entrance bulletin board was two stars. The CMS star rating for the facility at the time of the survey was one star. On 03/12/2025 during the morning, the facility's website lacked documented evidence of the facility's current star rating. On 03/12/2025 at 8:38 AM, the Nurse Consultant confirmed the facility's posted star rating in the bulletin board was 2 stars. The State Home Liaison Officer confirmed the facility's current star rating was one star and was not correctly posted in the facility and was absent from the facility's website. Severity: 1 Scope: 3	530	**1.** During survey, the star rating was immediately corrected and posted in a conspicuous area, with the update also reflected on the facility's website. No residents identified as being affected. **2.** The Administrator and MDS Coordinator were reeducated on the requirement for CMS star rating posting. The Administrator will track the facility star rating monthly and ensure that the website and posting in the facility remain current with current and accurate information. Monthly audits x 3 months to ensure that the facility posting and the website contain up to date star rating information. **3.** The Administrator or designee will perform monthly audits x 3 months to ensure compliance. Audits will be reviewed in the Monthly QAPI meeting x 3 months or until 100% compliance is achieved. **4.** Administrator **5.** June 6, 2025	06/06/2025
710 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	710	**1.** The Non-discrimination posting and facility website statements were immediately revised during the survey to reflect the updated Division contact information. No residents identified as	06/06/2025

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	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 ensure the facility's non-discrimination statement included the contact information for the Division and was posted prominently in the facility and on the Internet website used to market the facility according to Nevada Revised Statutes (NRS) 449.101. Findings include: On 03/12/2025 at 8:05 AM, the facility non-discrimination notice in the facility and on the facility's website lacked the contact information for the Division. On 03/12/2025 at 8:26 AM, the Nurse Consultant confirmed the contact information for the Division was not included on the facility's non-discrimination statement in the facility and on the facility's website.. Severity: 1 Scope: 3		being affected, but have the potential to be affected. **2.** The facility Administrator or designee will check the Division contact information posted both in the facility and on the website quarterly to ensure that the contact information is correct. The non-discrimination statement will be updated as needed if the contact information for the Division changes. **3.** Quarterly Audits will be reviewed in the Monthly QAPI meetings until 100% compliance is achieved for two consecutive quarters. **4.** Administrator **5.** June 6, 2025	
820 SS= D	Cultural Competency Training - NRS 449.103 Regulations requiring training relating specifically to cultural competency for certain agents or employees of facility; maintenance and distribution of list of approved courses and programs; request to provide unapproved course or program; reports. 1. Except as otherwise provided in	820	**1.** No residents were identified as affected, though all residents have the potential to be affected by the practice. Employees # 15, 16, 17, and 18 were	06/06/2025

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	subsection 3, to enable an agent or employee of 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 who is described in subsection 2 to more effectively treat patients or care for residents, as applicable, the Board shall, by regulation, require such a facility to conduct training relating specifically to cultural competency for any agent or employee of the facility who is described in subsection 2 so that such an agent or employee may better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who are: (a) From various racial and ethnic backgrounds; (b) From various religious backgrounds; (c) Persons with various sexual orientations and gender identities or expressions; (d) Children and senior citizens; (e) Persons with a mental or physical disability; and (f) Part of any other population that such an agent or employee may need to better understand, as determined by the Board. The Board shall set forth by regulation the frequency with which a medical facility, facility for the dependent or other facility is required to provide such training relating to cultural competency. 2. Except as otherwise provided in subsection 3, the requirements of subsection 1 apply to any agent or employee of 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 who: (a) Provides clinical, administrative or support services and has direct patient contact at least once each week on average as a part of his or her regular job duties; or (b) Oversees an agent or employee described in paragraph (a). 3. A medical facility, facility for the dependent or other facility is not required to provide training relating specifically to cultural competency to an agent or employee who is described in subsection 2 and who has successfully completed a course or program in cultural competency as part of the continuing education requirements for the agent or employee to renew his or her professional license, registration or		promptly enrolled in the next cultural competency course offered by the NHCA, scheduled for 4-25-25. People Culture Director, and the Staff Development Coordinator are reeducated on the Cultural Competency Training requirement. Facility implemented a revised Tracking System to ensure all staff have completed the Cultural Competency Training timely per requirement. Facility implemented a monthly review procedure on all staff compliance with the Cultural Competency Training requirement, to include the new hires. Additionally, updated new hire onboarding processes have been implemented to ensure timely compliance, including a reminder system for these requirements **3.** The People Culture Director or designee will perform monthly audits x 3 months to ensure compliance. Audits will be reviewed in the Monthly QAPI meeting x 3 months or until 100% compliance is achieved. **4.** Administrator **5.** June 6, 2025	

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	certificate, as applicable. 4. Except as otherwise provided in subsection 6, the training relating specifically to cultural competency conducted by 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 pursuant to subsection 1 must be provided through a course or program that is approved by the Department of Health and Human Services. Inspector Comments: Based on personnel record review, interview and document review, the facility failed to ensure cultural competency training was completed within the required timeframe for 4 of 20 sampled employees (Employee #15, #16, #17, and #19). The deficient practice placed residents at risk for receiving care from employees not completing all eligibility requirements prior to working with residents. Findings include: Employee #15 Employee #15 was hired as a Licensed Practical Nurse with a start date of 09/03/2024. Employees #15's personnel records documented evidence a cultural competency training was dated 12/30/2024. The training was not completed in the first 90 days. Employee #16 Employee #16 was hired as a Certified Nursing Assistant (CNA) with a start date of 08/01/2024. Employee #16's personnel records lacked documented evidence of cultural competency training. Employee #17 Employee #17 was hired as a CNA with a start date of 08/01/2024. Employee #16's personnel records lacked documented evidence of cultural competency training. Employee #19 Employee #19 was hired as Culinary Staff with a start date of 10/08/2024. Employee #19's personnel records documented evidence a cultural competency training dated 03/11/2025, five months after the employee's hire date. On 03/12/2025 at 2:00 PM, the Human Resources (HR) Director verbalized all staff were expected to complete cultural competency training. The HR Manager confirmed the aforementioned employees did not complete the cultural competency training within the required timeframe. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11715	A. BUILDING _____ B. WING _____	**03/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN NEVADA STATE VETERANS HOME	**36 BATTLE BORN WY, SPARKS, NEVADA ,89431**

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