

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2022
NAME OF PROVIDER OR SUPPLIER MASON VALLEY RESIDENCE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SOUTH STREET, YERINGTON, NEVADA ,89447	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey completed at your facility on 11/15/21 and a complaint investigation finalized on 01/10/22. This State Licensure 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 is licensed for 57 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, 45 Category II residents and 12 Category II (Alzheimer's) residents. The census at the time of the investigation was 28. Ten resident files were reviewed and eight employee files were 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. Complaint #NV00065275 was substantiated. The allegation medications were not on site was substantiated (See Tag Y 878). The allegation a PRN medication was not being administered following a physician order could not be substantiated, due to lack of evidence. The investigation into the allegation included: An interview was conducted with the Administrator. Review of five medical records including the resident of concern. Complaint #NV00065539 with the allegation residents tested positive for			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		Name: ROSEMARY A ORANTES	Title: Administrator	Date: 01/31/2022

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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0040 SS= D	COVID-19 due to facility staff infection control practices was substantiated (See Tag Y 593). The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified: Supervision of AGC - NRS 449.186 Supervision of residential facility for groups. A residential facility for groups must not be operated except under the supervision of an administrator of a residential facility for groups or a health services executive licensed pursuant to the provisions of chapter 654 of NRS. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure a licensed Administrator provided oversight and supervision of the facility. Findings include: On 11/15/21 at 9:15 AM, the Administrator's license from the Board of Examiners for Long Term Care Administrators (BELTCA) was not displayed. On 11/15/21 at 9:15 AM, the Medication Technician, seated at the reception area, verbalized the facility had an Administrator who had been at the facility for about a month. On 11/15/21 at 11:59 AM, the Acting Administrator explained they were hired on at the facility at the end of October 2021. The Acting Administrator explained no paperwork had been sent in to apply for the BELTCA license and confirmed the facility did not have an approved Administrator. Severity: 2 Scope: 3	0040	1. An updated license showing the new administrator was submitted in November and was approved at the beginning of December. The current administrator is now listed as the administrator on file with both BELTCA and HCQC. 2. The reason for the delay in submitting an application to HCQC was because the current supervisor staff at both the facility and the corporate level did not have any access to the ALias account. Therefore in order to gain access, the administrator had to go through the necessary steps to get approval. Which was receiving a written request by the CEO of the company and then sending that over to Michelle Smothers at HCQC. The current administrator created a new password and has now stored that information with both the corporate staff as well as having that information in an office handbook. 3. By having one person within the company that would have access to the licensure account, now a few people have access. The issue with getting the application submitted was just due to the fact that no one had access to the account. 4. Administration/Corporate office 5. 12/9/2021	12/09/2021			
0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are	0053	1. Residents #8 and #9 both came from the same skilled nursing facility. They both had received a negative chest x-ray prior to arriving in the building. At the time, per Mason Valley policy, chest x-rays were	01/30/2022			

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	complete and accurate. Inspector Comments: Based on record review, observation, and interview, the Acting Administrator failed to ensure resident clinical records were complete for 2 of 10 residents (Resident #8 and #9). Findings include: Resident #8 Resident #8 was admitted to the facility on 11/10/21, with a diagnosis of age-related debility, anxiety, and congestive heart failure. Resident #8's clinical record lacked documented evidence of an initial physical examination with a review of systems, Activities of Daily Living assessment, physician medication orders, and a two-step tuberculosis (TB) test. On 11/15/21 at 4:51 PM, the Acting Administrator confirmed the clinical record was incomplete for Resident #8. Resident #9 Resident #9 was admitted to the facility on 11/08/21, with a diagnosis of major depressive disorder, anxiety, chronic kidney disease, and chronic obstructive pulmonary disease. Resident #9's clinical record lacked documented evidence of an initial physical examination with a review of systems, Activities of Daily Living assessment, physician orders, and a two-step TB test. On 11/15/21 at 4:45 PM, the Acting Administrator confirmed the clinical record was incomplete for Resident #9. Severity: 2 Scope: 1		allowed as clearance for a TB clearance. It was explained at time of survey that a chest x-ray is accepted only after a positive TB has been obtained and the chest x-ray is used as verification that they are clear of TB. Both residents #8 and #9 both had not received an H&P in timely manner from the skilled nursing building, however did have DC summaries which had systems review. It was identified at the time of survey that a proper review of systems must be done prior. Due to limited services in our area, both residents did receive a review of systems however after admission. Both residents did receive care plans, and one was not available at the time of survey. Due to the fact that the care coordinator was out of the building at the time, the care plan was retrieved from her office the day after survey. Resident #8 has discharged from the building. A current medication list was present for both residents at time of move in from the skilled nursing building. Both residents have received ADL reviews, a current medication list and review of systems. Resident #9 now has a full review of systems, which is included. Currently, we are planning a discharge for resident #9. 2. The Administrator has made it a new policy that the following items must be received in the building prior to an admission date being set and a resident has moved in. These items include: 1. Negative 2 step TB test or Quantiferon 2. A current review of systems within the last 30 days signed by a physician and to be completed off of the facility form 3. A current physician order list of all medications At time of move in, an ADL form will be completed with family or POA. 3.A move-in checklist/audit, will be started	

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			at the time that a family has made the decision to move in. They will be given a pre-admission packet and with requirements of what must be received prior to an admit date. 4. Administrator/Care Coordinator 5. 1/30/22				
0102 SS= E	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure pre-employment physicals were completed for 2 of 8 employees (Employees #1 and #6). Findings include: Employee #1 Employee #1 was hired at the facility on 11/01/21, as the Administrator. Employee #1's personnel file lacked evidence a pre-employment physical was completed. Employee #6 Employee #6 was hired at the facility on 12/08/20, as a Caregiver. Employee #6's personnel file lacked evidence a pre-employment physical was completed. On 11/15/21 at 3:07 PM, the Acting Administrator verbalized pre-employment physicals were required to be completed prior to hire and provided to the facility. The Acting Administrator confirmed Employee #1 and Employee #6 lacked documented evidence pre-employment physicals were completed. Severity: 2 Scope: 2	0102	1. Employee #1 did have a pre-employment physical which was not located in the employee file. Employee #6 was hired in December 18 of 2020 and her physical was done prior to hiring, it was completed on September 09/18/2020. 2. The current HR coordinator has a created a pre-hire packet which includes the physical, tb and background check forms to be done prior to having an employee start with the building. 3. HR and the Administrator perform a checks and balances on the file prior to adding the new employee to the training schedule. 4. HR / Administrator 5. 12/18/20 and 11/15/21			11/15/2021	

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0104 SS= E	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 8 employees met the background check requirements of Nevada Revised Statute (NRS) 449.124 (Employee #1 and #4). Findings include: Employee #1 Employee #1 was hired at the facility on 11/01/21, as the Administrator. Employee #1's personnel file lacked proof of fingerprint submission within 10 days of hire, a Criminal History Statement, and a Nevada Automated Background Check System (NABS) clearance letter. Employee #4 Employee #4 was hired at the facility on 10/05/21, as the Payroll/Human Resources Specialist. Employee #4's personnel record lacked a NABS clearance letter. On 11/15/21 at 3:07 PM, the Acting Administrator verbalized proof of fingerprint submissions for a background check were required for all employees as a term of employment. In addition, the Criminal History Statements were required to be completed and a NABS clearance letter was required to be eligible for work. The Acting Administrator confirmed Employee #1 had not had their fingerprints done and submitted for employment, lacked a Criminal History Statement and a NABS clearance letter. The Acting Administrator confirmed Employee #4 lacked evidence of a NABS clearance letter. Severity: 2 Scope: 2	0104	1. With the new supervisor staff coming, the Administrator and the HR did not have access to the NABS account. The care coordinator instructed us to get our prints done, however we were not "ran" through the system. At the time of survey, Alicia Mazy one of the surveyors, gave the Administrator in guidance on how to gain access to NABS by reaching out to Todd South. The Administrator and HR were able to finally obtain access, including being eligible to run names in the system. Both the Administrator and the HR have now been able to get their background clearances. The HR's fingerprints were sent back and had to be re-ran due to OCR issues. 2. The new HR has created a handbook which includes logins, and contacts so that when new HR and Administrator's come into the building they will have access to all accounts, and will be able to make the necessary changes through the state contacts. The building is also referring all employees to Fingerprints Express to get electronic prints done. Prior to this the employees had fingerprint cards that had to be mailed in after getting fingerprinted. That created delays with the prints being lost in the mail and losing prints. By using the electronic process it has helped with speeding up the clearances. 3. By allowing more than one person in the building access to important accounts such as the NABS account, along with the handbook on the processes, Mason Valley should be able to avoid issues taking place. 4. HR/Administrator 5. 01/28/2022	01/28/2022
0593 SS= F	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The	0593	1. At the time of survey the building had not been following current policy of "all employees must wear a mask if they are within 6 feet of an resident." Resident's were not being asked to wear masks in	01/30/2022

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	administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: On 01/10/22 at 8:28 AM, upon entry to the facility, the Care Coordinator was not wearing a mask. On 01/10/22 at 9:36 AM, two maintenance workers were walking thought the facility not wearing masks. On 01/10/22 at 9:39 AM, the Care Coordinator verbalized some of the facility staff refused to wear masks. The Care Coordinator did not know the protocol for mask wearing as only being employed for approximately 3 months. The Care Coordinator verbalized the maintenance workers were advised to not enter resident rooms unmasked. On 01/10/22 at 10:27 AM, the Activity Director was at the reception area not wearing a mask. The Activity Director verbalized forgetting to put on a mask. On 01/10/22 at 10:30 AM, observed two residents in the activity room not wearing masks, and one resident walking in the hall not wearing a mask. Staff were observed not encouraging residents to wear a mask. On 01/10/22 at 10:27 AM, the Administrator verbalized staff should be wearing masks in the facility. The Administrator confirmed two residents had tested positive and were out of the facility. One resident tested positive on 12/19/21, and another resident tested positive on 01/03/22. The Administrator verbalized there were no positive residents or staff currently in the facility. A memo dated 04/02/20 to the employees of the Mason Valley Residence, documented all employees will wear a mask when within 6 feet of any resident. Masks will be worn when entering any resident's room. Severity: 2 Scope: 3 Based on observation and interview, the Acting Administrator failed to ensure a safe environment for 28 of 28 residents by 1) not ensuring staff, residents, and visitors were wearing masks, and 2) visitors entering the facility were screened for temperature and signs and		public areas and screening was at a minimum. 2. A position, front desk, was filled to ensure that #1: The front door be screened at all times, the front is to remain locked and all visitors must complete a screening form at the time of visit. #2: At the time of the complaint survey, the front desk employee was off that day and the care coordinator failed to properly screen. At the time of the complaint survey employees were still not wearing masks at all times. The changes that have been made since then: #1: A new policy has been created stating that all employees must wear masks while in the building. #2: All residents are asked to wear masks during activity times and while in common areas. Should a resident decline to wear a mask, the resident has the right but the caregiver will make a progress note stating same. #3: ALL employees, including the front desk employee, must screen visitors at the time of visiting. Their temperature must be read by the employee, and a screening form must be done prior to entering the building. The visitor understands that at the time of visiting they must wear a mask at all times. 3. By continuously educating staff about infection control such as hand washing, sanitizing and wearing masks. As well as screening visitors, the entire building is well aware of the actions being taken to try and control exposure. An in-service has taken place, as well as a letter to all families stating the same. 4. Administrator /Care Coordinator/Floor Supervisors				

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	symptoms of COVID-19. Findings include: On 11/15/21 at 9:15 AM, upon entry to the facility, the front desk receptionist was not wearing a mask and the State Surveyors were not screened for signs and symptoms of COVID-19. On 11/15/21 at 9:40 AM, the Activities Director was observed walking through the facility without a mask. The Activities Director verbalized staff were not required to wear masks. The Activities Director admitted they had not been trained on COVID-19 policies and procedures. On 11/15/21 at 9:43 AM, the front desk receptionist verbalized the facility did not currently follow CDC guidelines since the new Administrator started approximately one month ago; Masks were not mandatory for staff or residents. The front desk receptionist explained "anything goes" with the new Administrator and there was no routine testing for residents or employees. On 11/15/21 at 10:10 AM, the Acting Administrator was wearing a mask under their nose. The Acting Administrator verbalized the facility had lessened restrictions regarding COVID-19 due to the current low transmission rate in the county. The Acting Administrator did not know the current transmission rate. The Acting Administrator explained residents were not required to wear masks in the facility and residents deemed independent were allowed to leave the facility. The Acting Administrator confirmed staff were required to wear masks in the facility and visitors were required to be screen upon entry. The Acting Administrator confirmed the facility did not conduct routine testing for COVID-19 for residents and staff. On 11/15/21 at 11:05 AM, the Human Resources Director was observed walking through the facility and was not wearing a mask. The facility lacked documented evidence of COVID-19 policies and procedures. Severity: 2 Scope: 3 Complaint #NV00065539						

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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 interview and record review, the facility failed to ensure a physical examination including a review of systems was completed prior to admission for 2 of 10 residents (Resident #8 and #9). Findings include: Resident #8 Resident #8 was admitted to the facility on 11/10/21, with a diagnosis of age-related debility, anxiety, and congestive heart failure. Resident #8's record lacked documented evidence of an initial physical examination with a review of systems. On 11/15/21 at 4:44 PM, the Acting Administrator confirmed a physical examination with a review of systems was not completed for Resident #8 prior to admission. Resident #9 Resident #9 was admitted to the facility on 11/08/21, with a diagnosis of major depressive disorder, anxiety, chronic kidney disease, and chronic obstructive pulmonary disease. Resident #9's record lacked documented evidence of an initial physical examination with a review of systems. On 11/15/21 at 4:45 PM, the Acting Administrator confirmed a physical examination with a review of systems was not completed for Resident #9 prior to admission. Severity: 2 Scope: 1	0859	1. Resident #8 & #9 were admitted from the same facility. They both received a discharge summary from the skilled nursing facility but it was not an entire review of systems. Resident #9 received a full review of systems on 12/9/21. Resident #8 was discharged out on 11/20/21. 2. The Administrator has made it a new policy that the following items must be received in the building prior to an admission date being set and a resident has moved in. These items include: 1. Negative 2 step TB test or Quantiferon 2. A current review of systems within the last 30 days signed by a physician and to be completed off of the facility form 3. A current physician order list of all medications At time of move in, an ADL form will be completed with family or POA. 3.A move-in checklist/audit, will be started at the time that a family has made the decision to move in. They will be given a pre-admission packet and with requirements of what must be received prior to an admit date. 4. Administrator/Care Coordinator 5. 1/30/22	01/30/2022
0876 SS= E	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of	0876	1. Resident #7 has a POA, who was attempted to be reached several times. The POA did do a verbal authorization to all forms as he works nights and lives in Reno.	11/15/2021

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	facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to ensure an Ultimate User Agreement was signed upon resident admission for 4 of 10 sampled residents (Resident #7, #8, #9, and #10). Findings include: Resident #7 Resident #7 was admitted to the facility on 10/25/21, with a diagnosis of dementia. Resident #7's record lacked documented evidence of a signed Ultimate User Agreement. On 11/15/21 at 4:59 PM, the Acting Administrator confirmed the facility was administering Resident #7's medications and Resident #7's record lacked a signed Ultimate User Agreement. Resident #10 Resident #10 was admitted to the facility on 11/08/21, with diagnoses including multiple sclerosis, atrial fibrillation, anxiety, and depression. Resident #10's record lacked documented evidence of a signed Ultimate User Agreement. On 11/15/21 at 5:00 PM, the Acting Administrator confirmed the facility was administering Resident #10's medications and Resident #10's record lacked a signed Ultimate User Agreement. Resident #8 Resident #8 was admitted to the facility on 11/10/21, with a diagnosis of age-related debility, anxiety, and congestive heart failure. Resident #8's record lacked documented evidence of a signed Ultimate User Agreement. On 11/15/21 at 4:44 PM, the Acting Administrator confirmed Resident #8's record lacked a signed Ultimate User		POA was not able to physically sign any forms, resident passed in November 2021. Resident #8 did sign the ultimate user agreement however it was not filed at time of survey. Resident discharged in November of 2021. Resident #9 signed the ultimate user agreement at the time of survey. Resident #10 did sign the ultimate user agreement at admission, however it was not filed at time of survey. 2. The ultimate user agreement is now part of the family/resident pre-admission packet. This agreement must be signed prior to resident move in. 3. By having an admission audit checklist prior to move-in, a checks and balances between the care coordinator and the administrator, we can avoid non-filing of records in a timely manner as well as not missing documents. 4. Care Coordinator/Administrator 5. 11/15/2021	

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NAME OF PROVIDER OR SUPPLIER MASON VALLEY RESIDENCE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SOUTH STREET, YERINGTON, NEVADA ,89447			
(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		
	Agreement and admitted the facility was administering the resident's medications. Resident #9 Resident #9 was admitted to the facility on 11/08/21, with a diagnosis of major depressive disorder, anxiety, chronic kidney disease, and chronic obstructive pulmonary disease. Resident #9's record lacked documented evidence of a signed Ultimate User Agreement. On 11/15/21 at 4:45 PM, the Acting Administrator confirmed Resident #9's record lacked a signed Ultimate User Agreement and admitted the facility was administering the resident's medications. Severity: 2 Scope: 2						
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	0878	1. As mentioned in the SOD, various medications were not in building due to lack of refill or physician order. Since the survey, resident #9 and resident #10 both received updated medication orders and submitted to pharmacy for fill. Resident #9 was able to receive a refill order on 11/23/2021 to fill the gabapentin and magnesium oxide medications. Resident did come to the facility with medications. However did not have a 30 day supply. Resident #3 discharged out of the building on 11/23/2021. The medication was received in the building and at discharge was discharged with medications. Resident #10 has been able to get the medications filled. 2. Since the survey the building has merged all pharmacy orders over to Sierra Pharmacy and has hired a Medication Technician Supervisor. The medication tech supervisor's responsibility is to ensure that medications are refilled, that medications match the MAR and physician orders and medications are destroyed as they are dc'd or expired. Sierra Pharmacy has a liaison that has been coming out to the facility once a month to help with auditing the cart against the MAR and charts.		01/31/2022		

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	be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared 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 observation, record review and interview, the facility failed to transcribe medication administration instructions on the medication administration record (MAR) for 1 of 10 sampled residents (Resident #10), and to ensure medications were on site and available for 3 of 10 sampled residents (Resident #9, #3 and #10). Findings include: Resident #9 Resident #9 was admitted to the facility on 11/08/21, with diagnosis including chronic kidney disease, anxiety, depression, and insomnia. A physician order dated 11/08/21, documented magnesium oxide tablet 400 milligrams (mg), give one tablet by mouth in the morning for supplement. The magnesium oxide was not on-site and available to administer to Resident #9. A physician order dated 11/08/21, documented gabapentin capsule 100 mg, give 100 mg by mouth at bedtime for neuropathy. The gabapentin was not on-site and available to administer to Resident #9. On 11/15/21 at 4:14 PM, the Medication Technician confirmed the magnesium oxide and the gabapentin were not on site to administer to Resident #9. Resident #3 Resident #3 was admitted to the facility on 10/07/21, with diagnosis including encephalopathy, chronic obstructive pulmonary disorder, and epilepsy. The MAR for Resident #3 dated 11/2021, documented acetaminophen 325 mg, take two tablets by mouth every six hours, as needed for foot pain. The acetaminophen bottle for		3. By having audits at admission which include a 30 day script for medications and having a supervisor to oversee medications, the building will be better equipped to handle missing, expired or refills for medications. 4. Medication Technician Supervisor/Care Coordinator/Administrator 5. 1/31/2022	

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	Resident #3 lacked documentation of the physician name. The MAR for Resident #3 dated 11/2021, documented melatonin 5 mg tablets, take one tablet by mouth at bedtime. The melatonin bottle for Resident #3 lacked documentation of the physician name. On 11/15/21 at 4:00 PM, the Medication Technician confirmed the acetaminophen and melatonin lacked documentation of the physician name on the medication bottles for Resident #3. The MAR for Resident #3 dated 11/2021, documented Vimpat 200 mg tablet, take one tablet by mouth twice daily for seizures. The Vimpat was not on-site and available to administer to Resident #3. The MAR for Resident #3 dated 11/2021, documented looperamide 2 mg capsule, take four capsules by mouth initially then take one capsule every six hours as needed. The looperamide was not on-site and available to administer to Resident #3. The MAR for Resident #3 dated 11/2021, documented ondansetron ODT 4 mg tablet, take one tablet by mouth every six hours as needed. The ondansetron ODT was not on-site and available to administer to Resident #3. The facility was unable to provide physician orders for Vimpat, looperamide, and ondansetron ODT for Resident #3. On 11/15/21 at 4:00 PM, the Medication Technician confirmed the Vimpat, looperamide, and ondansetron ODT were note on site to administer to Resident #3. On 11/15/21 at 4:44 PM, the Acting Administrator verbalized the physician orders for Resident #3 were in another file. The Acting Administrator was not able to produce the physician orders. Resident #10 Resident #10 was admitted to the facility on 11/08/21, with diagnoses including depression, anxiety and atrial fibrillation. Resident #10's Medication Administration Record (MAR) dated November 2021, documented Lidocaine gel 2 percent. The MAR lacked administration instructions. Resident #10's physician order dated 09/27/21, documented Lidocaine gel 2			

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	percent. Apply to top of penis topically every four hours as needed for skin care. Resident #10's Lidocaine gel was not onsite and available to administer to the resident. On 11/15/21 at 4:35 PM, the Medication Technician confirmed the Lidocaine gel was not on-site and available to administer to Resident #10. The Medication Technician explained the Resident had never been administered this medication since admission to the facility and the physician nor the pharmacy had been contacted to inform the medication was not on-site nor administered. Resident #10's MAR dated November 2021, documented Nitroglycerin tablets. The MAR lacked administration instructions. Resident #10's physician order dated 07/13/21, documented Nitroglycerin tablet sublingual 0.4 mg. Give one tablet sublingually every five minutes as needed for chest pain times three doses. If no relief, call the Doctor. The Nitroglycerin tablets were not on-site and available to administer to Resident #10. On 11/15/21 at 4:25 PM, the Medication Technician verbalized the resident was not admitted to the facility with the nitroglycerin tablets and the MAR from the Resident's previous facility was copied and not compared with the physician orders. The Medication Technician confirmed the Nitroglycerin tablets were not on-site and available to administer to Resident #10. Resident #10's MAR dated November 2021, documented: -aspirin 81 milligram (mg). Take one tablet by mouth once a day for clot prevention. -Loratadine 10 mg. Take one tablet by mouth once a day for post nasal drip. -Lactobacillus capsule. Take one capsule by mouth in the morning for bowel health. -Omeprazole 20 mg. Take one tablet by mouth one time a day for acid indigestion. -Aspercream Lidocaine patch 4 percent lidocaine. Apply to lower back topically every 24 hours for pain and remove patch after 12 hours. Resident #10's physician order dated 07/13/21, documented aspirin tablet 81 mg. Take one tablet by mouth once a day for			

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	clot prevention. Resident #10's clinical record lacked documented evidence of a physician order for Loratadine 10 mg. Resident #10's physician order dated 12/27/20, documented Lactobacillus capsule. Give one capsule by mouth in the morning for bowel health. Resident #10's physician order dated 07/13/21, documented Omeprazole Tablet delayed release 20 mg. Give one tablet by mouth once a day for acid indigestion. Resident #10's physician order dated 08/03/21, documented Aspercream Lidocaine Patch 4 percent. Apply to lower back topically every 24 hours for pain. Remove after 12 hours on. Resident #10's aspirin bottle on-site lacked administration instruction per the physician order. Resident #10's Loratadine bottle on-site lacked administration instructions. Resident #10's Lactobacillus bottle on-site lacked administration instruction per the physician order. Resident #10's Omeprazole bottle on-site lacked administration instructions per the physician order. Resident #10's Aspercream package on-site lacked administration instructions per the physician order. On 11/15/21 at 4:15 PM, the Medication Technician confirmed the aspirin for Resident #10 lacked administration instructions to confirm proper administration to the Resident. The Medication Technician confirmed the Loratadine for Resident #10 lacked administration instructions to confirm proper administration to the Resident and was not sure if there was a physician order for the medication. The Medication Technician confirmed the Lactobacillus for Resident #10 lacked administration instructions to confirm proper administration to the Resident. The Medication Technician confirmed the Omeprazole for Resident #10 lacked administration instructions to confirm proper administration to the Resident. The Medication Technician confirmed the Aspercream for Resident #10 lacked administration instructions to confirm proper administration to the Resident.						

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	Resident #10's MAR dated November 2021, documented docusate sodium 100 mg. Take one capsule by mouth one time a day for constipation, hold for loose stool. Resident #10's physician order dated 07/13/21, documented docusate sodium 100 mg. Give one capsule by mouth one time a day for constipation. Hold for loose stool. Docusate sodium was not on-site and available to administer to Resident #10. On 11/15/21 at 4:10 PM, the Medication Technician confirmed docusate sodium was not on-site and available to administer to Resident #10. The Medication Technician explained the pharmacy would not drop the medication off and a staff member would have to go pick the medication up from the pharmacy. The Medication Technician was not confident the medication would be picked up for administration Resident #10's MAR dated November 2021, documented Voltaren gel 1 percent. Apply two grams transdermal every 8 hours as needed for pain to neck and bilateral shoulder. Unsupervised, may keep in room. Resident #10's physician order dated 12/22/20, documented Voltaren gel 1 percent. Apply two grams transdermally every 8 hours as needed for pain to bilateral shoulders and neck. Unsupervised self-administration, may keep at bedside. The Voltaren gel was not on-site and available to administer to Resident #10. On 11/15/21 at 4:30 PM, the Medication Technician confirmed the Voltaren gel was not on-site and available to administer to Resident #10. Resident #10's MAR dated November 2021, documented Camphor-eucalyptus-menthol patch. Apply to back topically every 24 hours as needed for pain management. Resident #10's physician order dated 08/22/20, documented Camphor-eucalyptus-menthol patch. Apply to back topically every 24 hours as needed for pain. The Camphor-eucalyptus-menthol patch was not on-site and available to administer to Resident #10. Resident #10's MAR dated November 2021, documented Camphor-			

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	eucalyptus-menthol ointment. Apply to chest topically every 12 hours as needed for congestion. Resident #10's physician order dated 10/23/20, documented Camphor-eucalyptus-menthol ointment. Apply to chest topically every 12 hours as needed for congestion. The Camphor-eucalyptus-menthol ointment was not on-site and available to administer to Resident #10. On 11/15/21 at 4:27 PM, the Medication Technician confirmed the Camphor-eucalyptus-menthol patch and ointment were not on-site and available to administer to Resident #10. Resident #10's MAR dated November 2021, documented Saline nasal spray. Two sprays in both nostrils as needed for dry nares. Resident #10's physician order dated 07/13/21, documented Saline nasal spray solution. Two sprays in both nostrils as needed for dry nares. The Saline nasal spray solution was not on-site and available to administer to Resident #10. On 11/15/21 at 4:26 PM, the Medication Technician confirmed the saline nasal spray solution was not on-site and available to administer to Resident #10. On 11/15/21, during medication review, there were two medications on-site for Resident #10. The medications lacked the resident name, physician and instructions to administer. The medications were the following: -Nystop, nystatin topical powder 100,000 units/gram. -Mint flavor gas ban 80 mg. The physician orders for the nystatin and mint flavor gas ban could not be located. On 11/15/21 at 4:21 PM, the Medication Technician confirmed there were two medications on-site for Resident #10 and did not have identifiable information transcribed on the medications. The Medication Technician verbalized the resident had admitted to the facility with the medications and no one checked for physician orders for the resident's medications. Resident #10's MAR dated November 2021, and the physician order dated 07/13/21, documented acetaminophen 325 milligram (mg). Take			

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	two tablets by mouth every six hours as needed for mild pain. The label on the medication for acetaminophen documented acetaminophen 500 mg. Take one tablet by mouth every six hours as needed for pain. On 11/15/21 at 4:16 PM, the Medication Technician confirmed the MAR and physician order for Resident #10 had a different dosage documented than the bottle on-site. The Medication Technician verbalized the bottle needed to document the correct dosage of acetaminophen at 325 mg. Severity: 2 Scope: 2 Complaint #NV00065275						
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 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; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 10 residents (Resident #3). Resident #3 Resident #3 was admitted to the facility on 10/07/21, with diagnosis including encephalopathy, chronic obstructive pulmonary disorder, and epilepsy. The MAR for Resident #3 dated 11/2021, documented acetaminophen 325 mg, take two tablets by mouth every six hours, as needed for foot pain. The acetaminophen bottle for Resident #3 lacked documentation of the physician name. The MAR for Resident #3	0895	1. At time of survey OTC's did not have a physician labeled. Resident has since discharged, dc date of November 30th. 2. We now have a medication technician supervisor along with a pharmacy liaison who comes out once a month. 3. Moving forward the med tech supervisor audits weekly, along with a grave yard supervisor and finally the liaison once a month. 4. Medication technician supervisor/Administrator 5. 11/30/2021		11/30/2021		

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	dated 11/2021, documented melatonin 5 mg tablets, take one tablet by mouth at bedtime. The melatonin bottle for Resident #3 lacked documentation of the physician name. On 11/15/21 at 4:00 PM, the Medication Technician confirmed the acetaminophen and melatonin lacked documentation of the physician name on the medication bottles for Resident #3. The MAR for Resident #3 dated 11/2021, documented Vimpat 200 mg tablet, take one tablet by mouth twice daily for seizures. The Vimpat was not on-site and available to administer to Resident #3. The MAR for Resident #3 dated 11/2021, documented looperamide 2 mg capsule, take four capsules by mouth initially then take one capsule every six hours as needed. The looperamide was not on-site and available to administer to Resident #3. The MAR for Resident #3 dated 11/2021, documented ondansetron ODT 4 mg tablet, take one tablet by mouth every six hours as needed. The ondansetron ODT was not on-site and available to administer to Resident #3. The facility was unable to provide physician orders for Vimpat, looperamide, and ondansetron ODT for Resident #3. On 11/15/21 at 4:00 PM, the Medication Technician confirmed the Vimpat, looperamide, and ondansetron ODT were note on site to administer to Resident #3. On 11/15/21 at 4:44 PM, the Acting Administrator verbalized the physician orders for Resident #3 were in another file. The Acting Administrator was not able to produce the physician orders.			
0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered.	0923	1. Resident #3 discharged on 11/30/21 Resident #10 had the HHA inhaler dc'd, and all medications have been refilled by pharmacy, which include pharmacy labels. 2. By having a medication technician supervisor to oversee the cart, weekly audits help ensure that medications are not expired, are refilled and the labels are correct.	11/30/2021

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	Inspector Comments: Based on observation, interview and record review, the facility failed to properly label medications with the resident's name and prescriber's name for 2 of 10 sampled residents (Resident #3 and #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 11/08/21, with diagnoses including depression, anxiety and atrial fibrillation. Resident #10's Medication Administration Record (MAR) dated November 2021, documented the following: -Ventolin HFA 10/ (90 base). Inhale two puffs orally every 6 hours as needed for shortness of breath. - Sennoside-docusate sodium 8.5/50 milligram (mg). Take two tablets by mouth every 24 hours as needed for constipation. - Polyethylene glycol 3350. Give 17 grams by mouth every 24 hours as needed for constipation. -Hydrocortisone cream. Apply to bilateral hand rash topically as needed for rash/itching. May apply two times per day. -Ibuprofen 200 mg. Take two tablets by mouth every 8 hours as needed for pain. Resident #10's physician orders documented the following: -Ventolin HFA Aerosol Solution 108 (90 base), dated 07/13/21. Inhale two puffs orally every 6 hours as needed for shortness of breath. - Sennosides Docusate Sodium tablet 8.6-50 mg, dated 04/21/21. Take two tablets by mouth every 24 hours as needed for constipation. -Glycolax Powder (Polyethylene Glycol 3350), dated 07/13/21. Give 17 grams by mouth every 24 hours as needed for constipation. -Hydrocortisone Cream 1 percent, dated 09/24/20. Apply to bilateral hand rash topically as needed twice daily for rash/itching. -Ibuprofen 400 mg tablet, dated 01/27/21. Give 400 mg by mouth every 8 hours as needed for pain. Resident #10's medications on site lacked documented evidence of the prescriber's name on the bottle. On 11/15/21 at 4:35 PM, the Medication Technician confirmed the Resident #10's medications lacked the		3. Weekly audits and a monthly audit by the pharmacy liaison has helped reduce errors on the med carts. 4. Med tech supervisor/Administrator 5. 11/30/21	

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	prescriber's name and verbalized the medications were to be labeled with the resident name, prescriber's name and instructions. Resident #3 Resident #3 was admitted to the facility on 10/07/21, with diagnosis including encephalopathy, chronic obstructive pulmonary disorder, and epilepsy. The MAR for Resident #3 dated 11/2021, documented acetaminophen 325 mg, take two tablets by mouth every six hours, as needed for foot pain. The acetaminophen bottle for Resident #3 lacked documentation of the physician name. The MAR for Resident #3 dated 11/2021, documented melatonin 5 mg tablets, take one tablet by mouth at bedtime. The melatonin bottle for Resident #3 lacked documentation of the physician name. On 11/15/21 at 4:00 PM, the Medication Technician confirmed the acetaminophen and melatonin lacked documentation of the physician name on the medication bottles for Resident #3. Severity: 2 Scope: 1						
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 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 record review and interview, the facility failed to ensure 5 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident	0936	1. Resident #7 was admitted from another Assisted living building, with a quantiferon positive test, a chest x-ray was done and both documents were in the file and were done within the past 6 months. Resident #3, 8,9,&10 were all admitted from the same skilled nursing building and all had chest x-rays from the hospital prior to their skilled nursing stay and had negative chest x-rays. We were told from skilled that was appropriate however at the time of survey it was told that it wasn't. Resident #3 and #8 has since discharged, however #9 and #10 are currently receiving their TB tests. 2. By using the pre-admission checklist, prior to admission, TB or quantiferon are the only acceptable forms for admitting patients. 3. By following the current guidelines, having that clearly labeled in the pre-		01/31/2022		

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	#3, #7, #10, #8 and #9). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/07/21, with diagnoses including encephalopathy, chronic obstructive pulmonary disease and epilepsy. Resident #3's record lacked documented evidence a two-step TB test was completed upon admission to the facility. On 11/15/21 at 3:07 PM, the Acting Administrator confirmed Resident #3 had not had a two-step TB test completed and verbalized TB tests needed to be completed prior to admission to the facility and annually thereafter. Resident #7 Resident #7 was admitted to the facility on 10/25/21, with a diagnosis of dementia. Resident #7's record lacked documented evidence a two-step TB test was completed upon admission to the facility. On 11/15/21 at 4:57 PM, the Acting Administrator confirmed Resident #7 had not had a two-step TB test completed and verbalized TB tests needed to be completed prior to admission to the facility and annually thereafter. Resident #10 Resident #10 was admitted to the facility on 11/08/21, with diagnoses including multiple sclerosis, atrial fibrillation, anxiety, and depression. Resident #10's record lacked documented evidence a two-step TB test was completed upon admission to the facility. On 11/15/21 at 4:59 PM, the Acting Administrator confirmed Resident #10 had not had a two-step TB test completed and verbalized TB tests needed to be completed prior to admission to the facility and annually thereafter. Findings include: Resident #8 Resident #8 was admitted to the facility on 11/10/21, with a diagnosis of age-related debility, anxiety, and congestive heart failure. Resident #8's record lacked documented evidence a two-step TB test was completed upon admission to the facility. On 11/15/21 at 4:44 PM, the Acting Administrator confirmed Resident #8 had not had a two-step TB test completed and verbalized TB tests needed to be completed prior to admission to the facility and annually thereafter. Resident #9 Resident		admission packet, the care coordinator can avoid other issues like this in the future. 4. Care Coordinator/Administrator 5. 1/31/22	

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	#9 was admitted to the facility on 11/08/21, with a diagnosis of major depressive disorder, anxiety, chronic kidney disease, and chronic obstructive pulmonary disease. Resident #9's record lacked documented evidence a two-step TB test was completed upon admission to the facility. On 11/15/21 at 4:45 PM, the Acting Administrator confirmed Resident #9 had not had a two-step TB test completed and verbalized TB tests needed to be completed prior to admission to the facility and annually thereafter. Severity: 2 Scope: 2						
0938 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 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 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 interview and clinical record review, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed upon admission for 5 of 10 sampled residents (Resident #3, #7, #10, #8 and #9). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/07/21, with diagnoses	0938	1. #3 and #8 were both discharged prior to having a care plan finally completed. #9 & #10 both had care plans completed however they were not filed at time of survey, they admitted a few days prior and the care coordinator was out. #7 did not have a care plan completed and passed away prior to completion. 2. With a new care coordinator starting and the administrator currently looking over all admissions at time of move in, care plans will be done in a timely manner. 3. We have also teamed with aging services on working on ADL's and by auditing charts will be able to adequately focus on getting them done correctly and timely. 4. Care Coordinator/Administrator 5. 11/15/21			11/15/2021	

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	including encephalopathy, chronic obstructive pulmonary disease and epilepsy. Resident #3's clinical record documented an initial ADL assessment on 10/07/21, however, the assessment was blank. On 11/15/21 at 3:07 PM, the Acting Administrator verbalized ADL assessments were required to be completed upon a resident admission to the facility and annually thereafter. The Acting Administrator confirmed Resident #7 did not have an ADL assessment completed upon admission and verbalized the form appeared to be a part of the admission packet to be signed without being completed. Resident #7 Resident #7 was admitted to the facility on 10/25/21, with a diagnosis of dementia. Resident #7's record lacked documented evidence an initial ADL assessment had been completed upon admission to the facility. On 11/15/21 at 4:59 PM, the Acting Administrator confirmed an initial ADL assessment had not been completed for Resident #7 upon admission. Resident #10 Resident #10 was admitted to the facility on 11/08/21, with diagnoses including multiple sclerosis, atrial fibrillation, anxiety, and depression. Resident #10's record lacked documented evidence an initial ADL assessment had been completed upon admission to the facility. On 11/15/21 at 5:00 PM, the Acting Administrator confirmed an initial ADL assessment had not been completed for Resident #10 upon admission. Resident #8 Resident #8 was admitted to the facility on 11/10/21, with a diagnosis of age-related debility, anxiety, and congestive heart failure. Resident #8's record lacked documented evidence an initial ADL assessment had been completed upon admission to the facility. On 11/15/21 at 4:44 PM, the Acting Administrator confirmed an initial ADL assessment had not been completed for Resident #8 upon admission. Resident #9 Resident #9 was admitted to the facility on 11/08/21, with a diagnosis of major depressive disorder, anxiety, chronic kidney disease, and chronic			

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	obstructive pulmonary disease. Resident #9's record lacked documented evidence an initial ADL assessment had been completed upon admission to the facility. On 11/15/21 at 4:45 PM, the Acting Administrator confirmed an initial ADL assessment had not been completed for Resident #9 upon admission. Severity: 2 Scope: 2						
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 and interview, the facility failed to ensure 5 of 5 residents in the memory care unit were safe from toxic substances. Findings include: On 11/15/21 at 9:49 AM, the door to the laundry room located just inside the exterior door in the memory care unit was unlocked and opened. The Medication Technician/Caregiver reached for the laundry room doorknob, turned the knob and the door opened. The laundry room contained several bottles of laundry detergent and fabric softener. The Medication Technician/Caregiver confirmed the laundry room was left unlocked and the room contained opened bottles of laundry detergent and fabric softener which could be harmful to residents if ingested. Severity: 2 Scope: 3	0999	1. At the time the door was left unlocked. Currently there is a sign stating "this door is to be remained lock while not in use." 2. By having maintenance doing a weekly audit of the building we can ensure that the proper doors are locked up. 3. Auditing and random sweeps of the building will take place. 4. Maintenance/Caregiver/Administrator 5. 1/31/22		01/31/2022		