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
MASON VALLEY RESIDENCE, LLC	**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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey and complaint investigations completed in your facility on 02/07/23, 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 and 12 Category II (Alzheimer's) residents. The census at the time of the survey was 39. Ten resident files and 12 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. Two complaints were investigated. Complaint #NV00067505 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: the facility did not have enough staff. Allegation #2: call lights were not being answered timely resulting in staff taking a long time to provide help. Allegation #3: no Serious Occurrence Report was completed for a resident incident. The investigation into the allegations included: Observations of eight residents in the resident's room. Interviews were conducted with eight residents, the Administrator, the Resident Care Coordinator, and a Caregiver/Medication Technician. Reviewed daily resident census	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROSEMARY ORANTES | Title: Administrator | Date: 05/24/2023

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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	reports and monthly Caregiver and Medication Technician schedules from 12/01/22 to 02/07/23. Complaint #NV00067779 with the allegation medication technicians were passing medications without a current certification was substantiated (See Tag Y0072). The following allegations could not be substantiated due to a lack of evidence: Allegation #1: resident medication administration records were not documented correctly. Allegation #2: narcotic medication went missing from medication carts. The investigation into the allegations included: Observations of Medication Technicians during medication review. Interviews were conducted with Medication Technicians during medication review, the Administrator and the Resident Care Coordinator. Reviewed three Medication Technician training records, sampled resident narcotic logs and Medication Administrator Records dated February 2023. 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 for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, record review, document review, and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAG Y0053, Y0065, Y0072, Y0074, Y0102, Y0104, Y0450, Y0557, Y0620, Y0859, Y0870, Y0874, Y0876, Y0878, Y0885, Y0936, Y0938, Y0994, Y0999, Y1035, Y1036, Y1037, Y1310, Y1520, Y1540, and Y1700. This was a repeat deficiency from the 09/13/22 complaint investigation survey. Severity: 2 Scope: 3	0050	1. The tags cited in the SOD have been identified and corrected. 2. New policies and processes have been done to ensure compliance. 3. By following the new policies and processed deficiencies should lessen. 4. Administrator 5. 04/06/23	04/06/2023

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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 complete and accurate. Inspector Comments: Based on record review and interview, the Administrator failed to ensure resident clinical records were complete for 1 of 10 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 02/02/23, with diagnoses including dementia, chronic obstructive pulmonary disease and interstitial lung disease. Resident #8's clinical record lacked evidence of an initial Activities of Daily Living, an Ultimate User Agreement, and a completed Admission Packet. On 02/07/23 at 2:23 PM, the Administrator confirmed Resident #8's clinical record was not completed and verbalized staff were still working on the documents for the resident. The Administrator explained the documents should have been completed upon admission and could not explain why an Admission Packet had not been completed for Resident #8, whom admitted to the facility five days ago. Severity: 2 Scope: 1	0053	1.This particular resident, admitted to our facility and discharged to the hospital 3 days later due to complications not addressed at prior facility. The ADL paperwork was completed however not at day of admission, but the day after admit. The entire admission paperwork was not fully completed at time of admission due to a family member other than the POA being with resident at time of admission. 2. The new policy that is implemented will be that POA must sign all admission paperwork at time of admission and must be with resident at time of admission. The ADL process will be handed over to the care coordinator and medication technician to go over medications and ADL's with family and resident. 3.An admission audit is used the day after admission to ensure that all forms are signed. However a step further, the process now adds that at time of deposit, the admission chart is created, the forms begin to be filed in the active chart along with a copy of all documents that are required at time of admission. At day of admission the chart is full, and the pending forms are signed in the chart at date of admission. It allows the process to be streamlined, and should remove any issues with missing forms, or forms not being filed at the time of signature. 4. Care Coordinator, Office assistant, Administrator 5. 04/06/2023	04/06/2023

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0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Inspector Comments: Based on employee record review and interview, the facility failed to ensure 1 of 12 sampled employees obtained annual caregiver training (Employee #2). Findings include: Employee #2 Employee #2 with a start date of 03/21/22, and a title of Resident Care Coordinator. Employee #2's record documented eight hours of annual caregiver training was completed on 12/02/19. Employee #2's record lacked documented evidence annual caregiver training had been completed since 12/02/19. On 02/07/23 at 3:10 PM, the Administrator confirmed Employee #2 and #10 had not completed annual caregiver trainings for 2020, 2021 or 2022. Severity: 2 Scope: 1	0065	1. Having started in 2022, the Care Coordinator was not employed in the building prior to 2022, therefore did not need to provide evidence of training to prior to that time. However the Care Coordinator, does have her training, but her certifications were not filed directly in her employee file as the building had filed all certs for each employee in separate file. 2. All certificates for the Care Coordinator, has been removed from the in-service binder and filed directly in her chart. All other employee certificates were also filed in the appropriate spot. 3. Having an assistant to do training's log and trainings, all certificates, caregiver training logs are kept logged and audited to ensure the facility is meeting compliance. 4. Care Coordinator Assistant, Front Desk 5. 04/06/23	04/06/2023
0072 SS= D	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a	0072	1. At the time of the complaint, the med technician had an expired license. Due to scheduling issues on renewing her license; the medication technician was unable to renew in a timely manner. 2. The Medication Technician supervisor is now responsible for medication technician licenses. The medication technician cited in	04/06/2023

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	resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on employee record review and interview, the facility failed to ensure 1 of 3 sampled employees who administered medications had current Medication Management training (Employee #5). Findings include: Employee #5 Employee #5 with a start date of 06/20/22, and a title of Medication Technician. Employee #5's record lacked documented evidence of Medication Management training. Staffing schedules dated December 2022 and January 2023, documented Employee #5 was scheduled as the Medication Technician on the night shift from 6:00 PM to 6:00 AM on 12/04/22, 12/05/22, 12/06/22, 12/07/22, 12/11/22, 12/18/22, 12/19/22, 12/20/22, 12/23/22, 12/24/22, 12/25/22, 12/26/22, 12/27/22, 12/28/22, 01/01/23, 01/02/23, 01/03/23, 01/08/23, 01/09/23, 01/10/23, 01/15/23, 01/16/23, 01/17/23, 01/22/23, 01/23/23, 01/24/23, 01/29/23, 01/30/23, and 01/31/23. On 02/07/23 at 10:18 AM, the facility provided the current employee list with titles and start dates. The employee list documented Employee #5 with a title of		this complaint is no longer employed with our building. The medication technician does a monthly audit to review licenses that may be expiring soon. 3.By keeping a list of expiration dates for the med techs, the supervisor will be able to properly keep track of certifications. 4. Medication Technician Supervisor 5. 04/06/2023	

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	Medication Technician. On 02/07/23 at 3:10 PM, the Administrator confirmed Employee #5 had not completed Medication Management training before administering medications to residents. Complaint #NV00067779 Severity: 2 Scope: 1			
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must	0074	1. Unfortunately the certifications were not filed directly in the employees file as the building had filed all certs for each employee in separate file. All caregivers are given an elder abuse training through the ADSD power-point website. 2. All certificates for the staff, have been removed from the in-service binder and filed directly in the charts. 3. Currently, the building has now started to have employees do the online training through Nevada Care Connect for their initial an annual training. An in-service for elder abuse will also be done twice a year to cover in person questions. All certificates generated from Nevada Care Connect, are sent to "MVRcare.training@gmail.com" and from the Care Coordinator assistant logs the certificates, and files the certificates. Currently an email was sent to all employees requesting the entire facility complete a new elder abuse training online. 4. Care Coordinator Assistant 5. 04/28/2023	04/28/2023

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	receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training			

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	required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on employee record review and interview, the Administrator of the facility failed to ensure 6 of 12 sampled employees completed annual training to recognize and prevent abuse of older persons (Employee #2, #3, #4, #6, #9, and #10), or initial training to recognize and prevent abuse of older persons before providing care to residents for 2 of 12 sampled employees (Employee #5 and #11). Findings include: Employee #2 Employee #2 with a start date of 03/21/22, and a title of Resident Care Coordinator. Employee #2's record documented annual training to recognize and prevent abuse of older persons was completed on 12/02/19. Employee #2's record lacked documented evidence annual training to recognize and prevent abuse of older persons had been completed in 2020, 2021 and 2022. Employee #3 Employee #3 with a start date of 06/25/10, and a title of Wellness Director. Employee #3's record lacked documented evidence of any training related to the recognition and prevention of abuse of older persons. Employee #4 Employee #4 with a start date of 05/16/17, and a title of			

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	Activities Director. Employee #4's record lacked documented evidence of any training related to the recognition and prevention of abuse of older persons. Employee #6 Employee #6 with a start date of 03/20/12, and a title of Medication Technician. Employee #6's record lacked documented evidence of any training related to the recognition and prevention of abuse of older persons. Employee #9 Employee #9 with a start date of 12/29/20, and a title of Medication Technician. Employee #9's record lacked documented evidence of any training related to the recognition and prevention of abuse of older persons. Employee #10 Employee #10 with a start date of 01/31/19, and a title of Caregiver. Employee #10's record lacked documented evidence of any training related to the recognition and prevention of abuse of older persons. Employee #5 Employee #5 with a start date of 06/20/22, and a title of Medication Technician. Employee #5's record lacked documented evidence of initial training to recognize and prevent abuse of older persons. Employee #11 Employee #11 with a start date of 12/28/22, and a title of Caregiver. Employee #11's record lacked documented evidence of initial training to recognize and prevent abuse of older persons. On 02/07/23 at 2:56 PM, the Administrator verbalized all training certificates had been removed from all employee records in October 2022. The Administrator verbalized a different State Agency had told the Administrator training certificates were no longer required and the Administrator had all training certificates removed from the employee records. The Administrator confirmed the records for Employee #2, #3, #4, #6, #9, and #10 lacked documented evidence of annual training to recognize and prevent abuse of older persons had been completed. The Administrator confirmed Employee #5 and #11 had been providing care to residents and the employee's records lacked documented evidence of initial training to			

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	recognize and prevent abuse of older persons had been completed. Severity: 2 Scope: 2			
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 employee record review and interview, the facility failed to ensure an annual tuberculosis (TB) screening had been completed for 5 of 12 sampled employees (Employee #2, #3, #4, #9, and #12), initial TB screening had been completed for 2 of 12 sampled employees (Employee #5 and #7), and annual TB sign and symptoms review had been completed for 2 of 12 sampled employees who had tested positive for TB (Employee #8 and #10). Findings include: Employee #2 Employee #2 with a start date of 03/21/22, and a title of Resident Care Coordinator. Employee #2's record documented a one-step annual TB screening completed on 12/01/21, with a negative result. Employee #2's record lacked documented evidence an annual TB screening had been completed in 2022. Employee #3 Employee #3 with a start date of 06/25/10, and a title of Wellness Director. Employee #3's record documented a one-step annual TB screening completed on 07/15/21, with a negative result. Employee #3's record lacked documented evidence an annual TB screening had been completed in 2022. Employee #4 Employee #4 with a start date of 05/16/17, and a title of Activities Director. Employee #4's record documented a one-step annual TB screening completed on 07/15/21, with a negative result. Employee #4's record lacked documented evidence an annual TB screening had been completed in 2022. Employee #9 Employee #9 with a start date of 12/29/20, and a title of	0102	1. Annual TB tests were not done for existing employees. 2. Annual TB's are now being directed to an outside agency to ensure they are being done annually. 3. An audit with due dates is now generated and it is up to the employee to get the TB completed within the time frame. Front desk assistant will generate a report monthly for all TB's due for the following month to ensure enough time is allowed to complete. 4. Front desk assistant 5. 04/06/2023	04/06/2023

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MASON VALLEY RESIDENCE, LLC	**705 SOUTH STREET, YERINGTON, NEVADA ,89447**

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	Medication Technician. Employee #9's record documented a QuantiFERON TB screening completed on 12/23/20, with a negative result. Employee #9's record lacked documented evidence an annual TB screening had been completed in 2021 and 2022. Employee #12 Employee #12 with a start date of 01/04/21, and a title of Housekeeper. Employee #12's record lacked documented evidence any TB screening had been completed since the employee's date of hire. Employee #5 Employee #5 with a start date of 06/20/22, and a title of Medication Technician. Employee #5's record documented a Signs and Symptoms Review for TB was completed on 06/20/22. Employee #5's record lacked documented evidence of an initial negative TB screening or a positive TB screening and a chest X-ray declaring the employee was free from disease. Employee #7 Employee #7 with a start date of 12/28/22, and a title of Caregiver. Employee #7's record lacked documented evidence an initial TB screening had been completed. Employee #8 Employee #8 with a start date of 09/06/06, and a title of Housekeeper. Employee #8's record documented a positive TB screening and chest X-ray dated 09/18/13, and a Signs and Symptoms Review for TB completed on 08/05/21. Employee #8's record lacked documented evidence a Signs and Symptoms Review for TB had been completed in 2022. Employee #10 Employee #10 with a start date of 02/31/19, and a title of Caregiver. Employee #10's record documented a positive TB screening and chest X-ray dated 02/02/19, and a Signs and Symptoms Review for TB completed on 01/15/21. Employee #10's record lacked documented evidence a Signs and Symptoms Review for TB had been completed in 2022 and 2023. On 02/07/23 at 3:07 PM, the Administrator confirmed TB screenings had not been completed on employees due to the cost of TB screening tests. Severity: 2 Scope: 2			

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0104 SS= D	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 employee record review and interview, the facility failed to ensure 3 of 12 employees met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #7, #11 and #12). Findings include: Employee #7 Employee #7 with a start date of 12/28/22, and a title of Caregiver. Employee #7's record lacked documented evidence fingerprints had been submitted to and a determination had been received from the Central Repository for Nevada Records of Criminal History. A Nevada's Automated Background Check System (NABS) search of Employee #7 resulted in no applicants matching the search criteria in the background checking system. Employee #11 Employee #11 with a start date of 12/28/22, and a title of Caregiver. Employee #11's record lacked documented evidence fingerprints had been submitted to and a determination had been received from the Central Repository for Nevada Records of Criminal History. A NABS search of Employee #11 resulted in no applicants matching the search criteria in the background checking system. Employee #12 Employee #12 with a start date of 01/04/21, and a title of Housekeeper. Employee #12's record lacked documented evidence fingerprints had been submitted to and a determination had been received from the Central Repository for Nevada Records of Criminal History. A NABS search of Employee #7 resulted in a determination of "Closed - Fingerprints Not Taken" and a new application must be submitted to the Central Repository for Nevada Records of Criminal History. On	0104	1. The background check process is not being done in a timely manner. 2. At time of offer of employment, before the start date; the employee is now given: physical, start of TB tests, and the fingerprint card to start the background check process. 3. Once the new hire returns the required documents, at the hire date or start date the employee will go through orientation and the NABS run will take place. By doing the background check at the hire date it allows the facility to stay in compliance of the process. 4. Office Assistant, Administrator 5. 04/06/2023	04/06/2023

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	02/07/23 at 3:13 PM, the Administrator confirmed it was the Administrator's responsibility to ensure employees were cleared through a background check to work in the facility, including having been responsible for submitting fingerprints to the Central Repository for Nevada Records of Criminal History. The Administrator confirmed the Administrator had not yet submitted the fingerprints of Employee #7, #11 and #12 to the Central Repository for Nevada Records of Criminal History. The Administrator confirmed Employee #7, #11 and #12 had been working since each of their start dates without a background check having been completed. Severity: 2 Scope: 1			

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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 employee record review and interview, the facility failed to ensure 5 of 12 sampled employees had completed cardiopulmonary resuscitation (CPR) and first aid training within the first 30 days of employment (Employees #5, #6, #7, #10, and #11). Findings include: Employee #5 Employee #5 with a start date of 06/20/22, and a title of Medication Technician. Employee #5's record lacked documented evidence of CPR and first aid training. Employee #6 Employee #6 with a start date of 03/20/12, and a title of Medication Technician. Employee #6's record lacked documented evidence of CPR and first aid training. Employee #7 Employee #7 with a start date of 12/28/22, and a title of Caregiver. Employee #7's record lacked documented evidence of CPR and first aid training. Employee #10 Employee #10 with a start date of 02/31/19, and a title of Caregiver. Employee #10's record lacked documented evidence of CPR and first aid training. Employee #11 Employee #11 with a start date of 12/28/22, and a title of Caregiver. Employee #11's record lacked documented evidence of CPR and first aid training. On 02/07/23 at 3:10 PM, the Administrator confirmed Employee #5, #6, #7, #10, and #11 had not completed CPR and first aid training within the first 30 days of employment. Severity: 2 Scope: 1	0450	1. Caregivers are not being certified within the 30 day period after hire date. Caregivers are now given a opportunity, monthly, to attend their initial certification training, or their 2 year cert training. 2. By working with an outside agency, and scheduling the new hire for the CPR at date of start date, when they are orientating, it will give the caregiver ample time to get the training. 3. A list of due dates for each employee has been compiled and put in a binder, the care coordinator assistant and the front desk assistant do a monthly audit to see who is due for the next month. By having 2 staff members on the audits it allows the facility to stay on top of the monthly requirements. 4. Care Coordinator Assistant, Front office assistant 5. 04/06/2023	04/06/2023
0557	Provision of Dental, Optical and Hearing	0557	1. Resident was admitted to facility with rails	04/06/202

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SS= D	Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure bedrails were not used as a restraint for 1 of 10 residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 01/22/23, with diagnoses including atrial fibrillation and hypertension. On 02/07/23 at 9:31 AM, Resident #10's bed had two half rails on each side of the bed, acting as a full side rail, and a bariatric trapeze above the bed. On 02/07/23 at 1:52 PM, Resident #10 explained the bedrails and bariatric trapeze were used to transfer out of the bed without assistance. The resident expressed they were not able to raise and lower the bedrails without assistance from the caregivers. On 02/07/23, a review of Resident #10's medical record revealed an initial evaluation of activities of daily living (ADL), dated 01/23/23, indicating the resident did not require assistance moving out of the bed. The medical record contained a Progress Note, dated 12/13/22, from the resident's medical practitioner. The progress note revealed Resident #10 was non ambulatory, not able to transfer out of the bed and not able to care for all personal needs, and not able to dress self. On 02/07/23 at 2:03 PM, the Medication Technician expressed the resident was able to get out of the bed without assistance as long as there was a caregiver standing by the resident's side to make sure the wheelchair was locked and the bedrails were down. On 02/07/23 at 2:41 PM, the Resident Care Coordinator expressed the half side bedrails and bariatric trapeze were		and trapeze that family brought from home. At of admission it was overlooked that the rails were being used for transfer. ADL careplan was completed at time of admission however it was not clear on the careplan that the resident needed assistance. Order was obtained for the bedrail. 2. After reviewing this tag and reviewing the careplan, the facility has decided to incorporate a more detailed careplan that explains transfers and other needs in a more clear and concise way. 3. By implementing a more detailed careplan, it will ensure that the care assessment is done and all needs are being met. 4. Care Coordinator 5. 04/06/2023	3

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	on the resident's bed so the resident could get in and out of bed. The Resident Care Coordinator confirmed the facility did not have a physician's order for the half side bedrails and bariatric trapeze for Resident #10. The facility policy titled "Use of Assistive Devices and Ambulatory Aids" implementation, documented the physician report and pre-admission documentation would be reviewed prior to placement, identifying resident need for assistive devices or mobility aids. Severity: 2 Scope: 1			
0620 SS= D	Written Policy on Admissions - NAC 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 2 of 10 sampled residents (Resident #4 and #5) and one unsampled resident (Resident #11). Findings include: On 02/07/23 at 3:23 PM, the Resident Care Coordinator verbalized the facility had residents receiving 24 hour skilled nursing care through home health and hospice agencies. The Resident Care Coordinator explained not being aware of the requirement to submit waivers to the State Agency for residents receiving 24 hour skilled nursing care. The Administrator confirmed the facility had not submitted waivers to the State Agency to retain residents receiving 24 hour skilled nursing care. Resident #4 Resident #4 was admitted to the facility on 05/29/14, with diagnoses including chronic kidney disease, diabetes, and hypertension. On 02/07/23 at 3:29 PM,	0620	1. Facility failed to submit hospice waivers for the hospice residents in the building. The forms were retrieved and completed. 2. Facility has completed the hospice forms. 3. As residents are referred to hospice the care coordinator will complete and fax over to HCQC prior to approval. 4. Care Coordinator 5. 04/06/2023	04/06/2023

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	the Resident Care Coordinator verbalized Resident #4 received 24 hour skilled nursing care from a home health agency. The Resident Care Coordinator confirmed the most recent home health certification date was 01/24/23. Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnoses including mild dementia, atrial fibrillation and chronic obstructive pulmonary disease. Resident #11 Resident #11 was admitted to the facility on 03/09/22, with diagnoses including senile dementia, uncomplicated, cerebral atherosclerosis and benign prostatic hyperplasia with lower urinary tract symptoms. On 02/07/23 at 3:29 PM, the Resident Care Coordinator verbalized Resident #5 and #11 were receiving 24 hour skilled nursing care from a home health agency. Severity: 2 Scope: 1			

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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 clinical record review, the facility failed to ensure a general physical examination was completed upon admission for 1 of 10 sampled residents (Resident #7) and a timely annual general physical examination was completed for 1 of 10 sampled residents (Resident #5). Findings include: Resident #7 Resident #7 was admitted to the facility on 05/25/22, with diagnoses including chronic obstructive pulmonary disease, obesity and gastroesophageal reflux disease. Resident #7's clinical record included a general physical examination dated 07/26/22. On 02/07/23 at 3:23 PM, the Resident Care Coordinator confirmed the resident's general physical examination was not completed on or before admission. Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnoses including mild dementia, atrial fibrillation and chronic obstructive pulmonary disease. Resident #5's clinical record documented a general physical examination dated 03/31/21 and an annual general physical exam dated 08/07/22, five months late. On 02/07/23 at 3:23 PM, the Administrator confirmed Residents #7 and #5's general physical examinations were not completed timely and verbalized physical exams were to be completed upon admission to the facility and annually thereafter. Severity: 2 Scope: 1	0859	1. Annual physical was late due to resident denying physician visit. The initial assessment prior to admission for a the new resident was over looked. 2. The new process now adds that at time of deposit,the admission chart is created, the forms begin to be filed in the active chartalong with a copy of all documents that are required at time of admission. The admission assessment is due prior to scheduling an admission. The annual physical will be done in house by the outside physician that now does rounds in the building. All new physicians assessments were done in March when the new provider started. 3. No admissions will be done before all prior documentation is done. An audit was completed on all existing residents and as annuals are due a new physician form is done by the in house provider. 4. Care coordinator assistant/Care Coordinator 5. 04/06/2023	04/06/2023

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of 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 interview and clinical record review, the facility failed to ensure a resident admitted for six months or greater had a review of medications for accuracy and appropriateness for 1 of 10 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnoses including mild dementia, atrial fibrillation, and chronic obstructive pulmonary disease. Resident #5's clinical record lacked documented evidence medication reviews had been completed no later than six months after admission to the facility and subsequently every six months after. On 02/07/23 at 2:23 PM, the Administrator confirmed Resident #5 lacked evidence of six month medication reviews and verbalized medication reviews were to be completed no later than six months after	0870	1. Medication pharmacy reviews are done automatically twice a year, January and July. However as new residents come in and miss the reporting mark, some new residents were missed. 2. The medication technician supervisor, or wellness coordinator, will now keep a log of new residents who come in and when their 6 month is due. If it is prior to when the next report is processed the pharmacy will be notified for the review. 3. The medication technician will keep a log to ensure reviews aren't missed after an initial admission, which means that within the first year of admission a resident may have 2 to 3 reviews; one to be in compliance and the others to be in the twice yearly report. 4. Medication technician supervisor 5. 04/06/2023	04/06/2023

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	admission to the facility and every six months thereafter. Severity: 2 Scope: 1			
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist or registered nurse at least once every six months, was initialed by the Administrator for 4 of 10 sampled residents residing in the facility for longer than six months (Resident #4, #7, #6, and #1). Findings include: Resident #4 Resident #4 was admitted to the facility on 05/29/14, with diagnosis including chronic kidney disease, diabetes and hypertension. Resident #4's file contained a medication reviews dated 07/19/22 and 01/17/23, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #7 Resident #7 was admitted to the facility on 05/25/22, with diagnoses including chronic obstructive pulmonary disease, obesity and gastroesophageal reflux disease. Resident #7's file contained a medication reviews dated 08/11/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #6 Resident #6 was admitted to the facility on 07/21/14, with a diagnosis including essential tremors, hypothyroid, gerd, high density lipoprotein, and depression. Resident #6's file contained a medication	0874	1. Unfortunately on the last pharmacy review report, the first desk was not aware that the forms must be signed by the administrator as a signature line was not on the review. 2. Facility asked pharmacy to add signature line for the administrator. The appropriate staff: med tech supervisor, front desk assistant, care coordinator assistant and care coordinator were all trained on the administrator signature requirement. 3. Staff has been directed that the reviews may not be filed prior to being signed. All forms were pulled from files that were not signed. 4. Care Coordinator/Med tech supervisor/Front Desk assistant/Care Coord Assistant/Administrator 5. 04/06/2023	04/06/2023

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(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
	reviews dated 03/02/22 and 02/26/21, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #1 Resident #1 was admitted to the facility on 05/02/22, with diagnoses including dementia, alcohol abuse and atropathy. Resident #1's file documented a medication reviews dated 11/30/22 and 01/17/23, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. On 02/07/23 at 2:23 PM, the Administrator confirmed Resident #4, #7, #6 and #1 lacked documented evidence of the Administrator's or the Designee's signature indicating a review of the reports and verbalized all medication reviews were to have the Administrator's or Designee's signature present on the reviews confirming review of the report. The Administrator explained the facility had ordered a stamp of the Administrator's signature and staff were supposed to stamp each medication review and the Administrator was not reviewing for accuracy of the reports. Severity: 1 Scope: 2			

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

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 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 NAC 449.1985 are met. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure a resident had a valid Ultimate User Agreement authorizing the facility to store and administer medications for 1 of 10 sampled residents (Resident #8). Resident #8 Resident #8 was admitted to the facility on 02/02/23, with diagnoses including dementia, chronic obstructive pulmonary disease and interstitial lung disease. Resident #8's clinical record lacked documented evidence of an Ultimate User Agreement. On 02/07/23 at 2:23 PM, the Administrator confirmed the facility stored and administered medications for Resident #8 and the resident did not have an Ultimate User Agreement completed. Severity: 2 Scope: 1	0876	1. Ultimate user agreement was misfiled and was unable to be located at time of survey. Ultimate user agreement was located and filed correctly. 2. An admission audit is used the day afteradmission to ensure that all forms are signed. However a step further, theprocess now adds that at time of deposit, the admission chart is created, theforms begin to be filed in the active chart along with a copy of all documentsthat are required at time of admission. At day of admission the chart is full,and the pending forms are signed in the chart at date of admission 3.It allows the process to be streamlined, andshould remove any issues with missing forms, or forms not being filed at thetime of signature. With the ultimate user agreement already being filed in the chart, during the admission it is pulled, signed and refiled. 4. Front office assistant/Administrator/Medication tech supervisor 5. 04/06/2023	04/06/2023
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	0878	1. At time of admission it was overlooked that resident did not have an oxygen order. Oxygen order was obtained at time of finding. 2. Prior to admission, the medication list will be looked over against the order set list from the provider. 3. Any oxygen in the facility will be audited in the facility to ensure a correct and signed order is filed. 4. Care coordinator	04/06/2023

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	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 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 ensure a physician's order was obtained for the administration of Oxygen for 1 of 10 residents (Resident #10) and medications were on-site to administer as prescribed for 1 of 10 residents (Resident #5). Findings include: Resident #10 Resident #10 was admitted to the facility on 01/22/23, with diagnoses including atrial fibrillation and hypertension. On 02/07/23 at 1:52 PM, Resident #10 was receiving Oxygen via nasal cannula at 2		5. 04/06/2023	

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	liters per minute. Resident #10's record lacked documented evidence of a physician's order for the administration of Oxygen. On 02/07/23 at 2:43 PM, the Resident Care Coordinator verbalized there was no order for the administration of Oxygen in the resident's record. Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnoses mild dementia, chronic obstructive pulmonary disease and prostate cancer. Resident #5's physician order, dated 11/02/22, documented Senna-docusate 8.6-50 milligram (mg), take one tablet by mouth as needed (PRN) for constipation. The resident's medication was not on-site to administer as prescribed. Resident #5's February 2023 Medication Administration Record (MAR) documented Senna-docusate 8.6-50 milligram (mg), take one tablet by mouth as needed for constipation. The PRN medication was not available on site. On 02/07/23 at 2:15 PM, the Medication Technician confirmed the facility lacked Resident #5's PRN Senna-docusate and would have the pharmacy deliver a new bottle. Severity: 2 Scope: 1			

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure a discontinued medication was destroyed and not stored with a resident's current medications for 1 of 10 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnoses mild dementia, chronic obstructive pulmonary disease and prostate cancer. On 02/07/23, during review of the resident's medications, a medication bottle of phenazopyridine 200 milligram (mg) tablets was in the storage area for Resident #5's medications. On 02/07/23 at 2:19 PM, the Medication Technician (MT) verbalized the phenazopyridine had been discontinued and discontinued medications were supposed to be destroyed when they were discontinued. An order dated 08/31/22, documented to discontinue the phenazopyridine. Severity: 2 Scope: 1	0885	1. Medication was not destroyed at time of expiration or at order discharged. 2. Monthly the medication supervisor tech and the pharmacy liasion review all med carts. 3. The medication supervisor will do a second check each month to ensure all medications are current in the cart. 4. Medication technician supervisor 5. 04/06/2023	04/06/2023
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that	0936	1. It was identified that an annual TB was done in a timely manner for each resident. 2. An audit was completed to show all due dates. 3. Currently the facility is working on obtaining TB serum so that the new in house provider can do resident annual tb's. The tb's will be done at time of annual physical.	04/06/2023

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	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 3 of 10 sampled residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #5, #6 and #4). Findings include: Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnosis including mild dementia, atrial fibrillation and chronic obstructive pulmonary disease. Resident #5's clinical record documented a Quantiferon TB test completed on 02/10/21 and an annual Quantiferon TB test completed on 04/20/22, with a negative result. The annual TB test completed on 04/20/22, was two months late. On 02/07/23 at 2:23 PM, the Administrator confirmed Resident #5's annual TB test was two months late and verbalized all residents were to have a TB test completed upon admission and annually thereafter. The annual TB tests were to be completed by the end of the same month as the previous year. Resident #6 Resident #6 was admitted to the facility on 07/21/14, with a diagnosis including essential tremors, hypothyroid, gerd, high density lipoprotein, and depression. Resident #6's clinical record documented a one step TB test given 07/13/21 and read negative on 07/15/21; however, the residents clinical recorded lack documented evidence of an annual one step TB test for 2022. On 02/07/23 at 2:28 PM, the Resident Care Coordinator confirmed Resident #6 lacked annual TB testing for 2022. Resident #4 Resident #4 was admitted to the facility on 05/29/14, with a diagnosis including diabetes, chronic kidney disease, and		4. Care coordinator 5. 04/06/2023	

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	hypertension. Resident #4's clinical record documented a one step TB test given 07/13/21 and read negative on 07/15/21; however, the residents clinical recorded lack documented evidence of an annual one step TB test for 2022. On 02/07/23 at 3:23 PM, the Resident Care Coordinator confirmed Resident #4 lacked annual TB testing for 2022. Severity: 2 Scope: 1			
0938 SS= F	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 document review, the facility failed to ensure an initial and/or annual Activities of Daily Living (ADL) Assessment was completed for 10 of 10 sampled residents (Resident #4, #7, #10, #2, #3, #6, #1, #5, #8 and #9). Findings include: Resident #4 Resident #4 was admitted to the facility on 05/29/14, with diagnosis including diabetes hypertension and chronic kidney disease. Resident #4's clinical record lacked an annual 2022 ADL Assessment. Resident #7	0938	1. It was identified that initial ADL assessments were not completed at time of admission. They were completed however they were done a day or days after admission. 2. It was instructed to care coordinator that the ADL needs to be done at time of admission. 3. Care coordinator's primary role at admission is to ensure needs are met and recorded on the ADL. 4. Care coordinator 5. 04/06/2023	04/06/2023

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	Resident #7 was admitted to the facility on 05/25/22, with diagnosis including chronic obstructive pulmonary disease, gastroesophageal reflux disease and obesity. Resident #7's clinical record lacked an initial ADL Assessment Resident #10 Resident #10 was admitted to the facility on 01/23/23, with diagnosis including atrial fibrillation and hypertension. Resident #10's clinical record lacked an initial ADL Assessment. Resident #2 Resident #2 was admitted to the facility on 10/18/22, with a diagnosis including atrial fibrillation, hyperparathyroidism, and chronic obstructive pulmonary. Resident #2's clinical record lacked an initial ADL Assessment. Resident #3 Resident #3 was admitted to the facility on 09/26/22, with a diagnosis including dementia, high cholesterol, agitation due to dementia, and anxiety. Resident #3's clinical record lacked an initial ADL Assessment. Resident #6 Resident #6 was admitted to the facility on 07/21/14, with a diagnosis including essential tremors, hypothyroid, gerd, high density lipoprotein, and depression. Resident #6's clinical record lacked an annual 20ADL Assessment. Resident #1 Resident #1 was admitted to the facility on 05/02/22, with diagnoses including dementia, alcohol abuse and atrophathy. Resident #1's clinical record lacked documented evidence an initial ADL assessment had been completed. Resident #5 Resident #5 was admitted to the facility on 04/15/21, with diagnoses including mild dementia, atrial fibrillation and chronic obstructive pulmonary disease. Resident #5's clinical record documented an initial ADL assessment completed on 04/18/21 and an annual ADL assessment completed on 08/31/22, four months late. The annual ADL assessment, dated 08/31/22, was incomplete. Resident #8 Resident #8 was admitted to the facility on 02/02/23, with diagnoses including dementia, chronic obstructive pulmonary disease, and interstitial lung disease. Resident #8's			

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	clinical record lacked documented evidence an initial ADL assessment had been completed. Resident #9 Resident #9 was admitted to the facility on 05/05/22, with diagnoses including coronary artery disease, essential hypertension and hyperlipidemia. Resident #9's clinical record documented an initial ADL assessment completed on 05/05/22. The ADL assessment was incomplete. On 02/07/23 at 10:43 AM, the Resident Care Coordinator explained the current ADL forms used by the facility were vague and did not document how many caregivers were needed to assist residents with activities of daily living. The Resident Care Coordinator verbalized the ADL assessments completed were invalid and caregivers would not know how to properly assist residents by looking at the ADL assessments. On 02/07/23 at 2:23 PM, the Administrator confirmed Resident #4, #7, #10, #2, #3, #6, #1, #5, #8 and #9 lacked completed ADL assessments and verbalized ADL assessments were to be completed upon admission to the facility and annually thereafter. The Administrator explained all ADL assessments were to define how much assistance a resident needed with activities of daily living. Severity: 2 Scope: 3			

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0994 SS= E	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, interview and document review, the facility failed to ensure dangerous items were secured in the common area of the memory care unit and in 1 resident room (Room #40). Findings include: On 02/07/23 at 9:01 AM, located in room #40 were the following unsecured items: -One pencil. -One pen. On 02/07/23 at 9:10 AM, located in the common area of the memory care unit, inside two unlocked drawers were the following items: -One pencil. On 02/07/23 at 9:12 AM, the Medication Technician confirmed the dangerous items located in an occupied resident room, room #40 and in the common area of the memory care unit. The Medication Technician verbalized all dangerous items were to be secured at all times to prevent residents from injuring themselves and others. Severity: 2 Scope: 2	0994	1. The memory care unit had toiletry items and unsecured drawers. 2. An in-service was done with staff to go over the requirements in the dementia unit. 3. Audits are being done twice weekly by supervisors to ensure all drawers are locked and hygiene items are put away. 4. All supervisors 5. 04/06/2023	04/06/2023

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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 residents were safe from toxic substances for 7 of 7 residents residing in the memory care unit. Findings include: On 02/07/23 at 9:01 AM, located in room #40 were the following unsecured items: -Baby Lotion, 4 fluid ounces. -Hand sanitizer, two fluid ounces. -Polident. -Two bags of make-up. -One container of face lotion. -Softsoap body wash, 20 ounces. -Mary Kay Berry and Vanilla shower gel, 6.7 ounces. -Apricot scrub face wash, 6 ounces. On 02/07/23 at 9:01 AM, the Medication Technician confirmed the items were unsecured in an occupied resident room and verbalized all toxic substances were to be secured at all times and verbalized residents could consume the products, causing illness or death. On 02/07/23 at 9:10 AM, located in the common area of the memory care unit, inside two unlocked drawers were the following items: -Four color splash purple glue sticks. -Two unmarked glue containers. -Six markers. -One Sharpie marker. On 02/07/23 at 9:12 AM, the Medication Technician confirmed toxic items were unsecured in the common area and verbalized all residents needed to be kept safe by securing all toxic items to avoid residents consuming toxic substances. Severity: 2 Scope: 3	0999	1. The memory care unit had toiletry items and unsecured drawers. 2. An in-service was done with staff to go over the requirements in the dementia unit. 3. Audits are being done twice weekly by supervisors to ensure all drawers are locked and hygiene items are put away. 4. All supervisors 5. 04/06/2023	04/06/2023

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1035 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family. Inspector Comments: Based on employee record review and interview, the Administrator failed to ensure 2 of 12 sampled employees received two hours of Alzheimer's training within the first 40 hours of employment (Employee #5 and #7). Findings include: Employee #5 Employee #5 with a start date of 06/20/22, and a title of Medication Technician. Employee #5's record lacked documented evidence two hours of Alzheimer's training was completed within the first 40 hours of employment. Employee #7 Employee #7 with a start date of 12/28/22, and a title of Caregiver. Employee #7's record lacked documented evidence two hours of Alzheimer's training was completed within the first 40 hours of employment. On 02/07/23 at 3:10 PM, the Administrator confirmed Employee #5 and #7's records lacked documented evidence of two hours of Alzheimer's training within the first 40 hours of employment. Severity: 2 Scope: 1	1035	1. Dementia training is done at time of start date, however the appropriate certificates were not filed in the files but in a binder. 2. All certificates for the employees been removed from the in-service binder and filed directly in their charts. 3. Having an assistant to do training's log andtrainings, all certificates, caregiver training logs are kept logged andaudited to ensure the facility is meeting compliance. 4. Care coordinator assistant/front desk assistant 5. 04/06/2023	04/06/2023

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
MASON VALLEY RESIDENCE, LLC	**705 SOUTH STREET, YERINGTON, NEVADA ,89447**

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1036 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease. Inspector Comments: Based on employee record review and interview, the Administrator failed to ensure 1 of 12 sampled employees received eight hours of Alzheimer's training within 90 days of the employees start date (Employee #5). Findings include: Employee #5 Employee #5 with a start date of 06/20/22, and a title of Medication Technician. Employee #5's record lacked documented evidence eight hours of Alzheimer's training was completed within 90 days from the employees start date. On 02/07/23 at 3:10 PM, the Administrator confirmed Employee #5's record lacked documented evidence of eight hours of Alzheimer's training within 90 days from the employees start date. Severity: 2 Scope: 1	1036	1.Dementia training is completed by 90 days, however the appropriate certificates were not filed in the files but in a binder. 2. All certificates for the employees been removed from the in-service binder and filed directly in their charts. 3. Having an assistant to do training's log and trainings, all certificates, caregiver training logs are kept logged and audited to ensure the facility is meeting compliance. Currently all caregivers are now doing online trainings from www.alz.org, and then required to email certs within their first 90 days and also for existing employees. 4. Care coordinator assistant/front desk assistant 5. 04/06/2023	04/06/2023
1037 SS= F	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any	1037	1. Annual dementia training was missing for some staff due to certificates not being located in their files. 2. All certificates for the employees been removed from the in-service binder and filed directly in rhe chart. 3. Having an assistant to do training's	04/20/2023

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	form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on employee record review and interview, the Administrator failed to ensure 8 of 12 sampled employees received at least 3 hours of annual Alzheimer's training on or before the employee's anniversary date (Employee #1, #3, #4, #6, #8, #9, #10, and #12). Findings include: Employee #1 Employee #1 with a start date of 10/16/21, and a title of Administrator. Employee #1's record documented three hours of annual Alzheimer's training was completed on 12/25/21. Employee #1's record lacked documented evidence three hours of annual Alzheimer's training was completed in 2022.		log andtrainings, all certificates, caregiver training logs are kept logged andaudited to ensure the facility is meeting compliance. Currently caregivers are doing online trainings due 04/20/2023. 4. Care Coordinator Assistant, Front Desk 5. 04/20/23	

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	The following employee records lacked documented evidence any Alzheimer's training had been completed: -Employee #3 with a start date of 06/25/10, and a title of Wellness Director. -Employee #4 with a start date of 05/16/17, and a title of Activities Director. -Employee #6 with a start date of 03/20/12, and a title of Medication Technician. -Employee #8 with a start date of 09/06/06, and a title of Housekeeper. -Employee #9 with a start date of 12/29/20, and a title of Medication Technician. -Employee #10 with a start date of 02/31/19, and a title of Caregiver. -Employee #12 with a start date of 01/04/21, and a title of Housekeeper. On 02/07/23 at 3:10 PM, the Administrator confirmed Employee #1, #3, #4, #6, #8, #9, #10, and #12's records lacked documented evidence of three hours of annual Alzheimer's training. 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	1310	1. A non discrimination form was posted however the complaint information or contact information was not listed on that form. 2. A new posting was created and posted with the complaint information and contact information. The new posting is located in the dining area on the bulletin board. 3. The posting is located in a space that can be viewed by all visitors. 4. Front office assistant 5. 04/06/2023	04/06/2023

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	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 the contact information for the Division where a resident, who had experienced prohibited discrimination, may file a complaint. Findings include: On 02/07/23 at 10:00 AM, the facility lacked posted documentation of the Division's contact information where to file a complaint for any resident who may have experienced discrimination. On 02/06/23 at 10:10 AM, the Administrator confirmed the facility had not posted the Division's contact information, where a resident may file a discrimination complaint. Severity: 1 Scope: 3			
1520 SS= C	Copy of Statement/Filing a Complaint - R016-20 Section 11 1. Upon admission of a patient or resident, the facility shall: (a) Provide the patient or resident with a written copy of the statement required pursuant to paragraph (b) of subsection 2 of NRS 449.101 and the notice and information required pursuant to subsection 3 of NRS 449.101 or section 9 of this regulation, as applicable. (b) Provide the patient or resident with a written notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the facility. The written notice provided by the facility must include, without limitation: (1) The contact information for the Division; (2) A clear statement that such a complaint with the facility: (I) May be filed in addition to the complaint that may be filed with the Division pursuant to subsection 3 of NRS 449.101 or section 9 of this regulation, as applicable; and (II) Is not required to be filed for the patient or resident to file a complaint with the Division pursuant to subsection 3 of NRS 449.101 or section 9 of this regulation,	1520	1. A non discrimination form was not located in the admission packet. 2. A form has been created along with a signature line for every resident in the facility. 3. The new form has been implemented in the admission packet. 4. Front office assistant 5. 04/06/2023	04/06/2023

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	as applicable; and (3) The procedure that the facility uses to address such complaints with the facility and the timeframe for how long it will take the facility to address such complaints with the facility. 2. As used in this section, "prohibited discrimination" means the discrimination described in section 7 of this regulation and in subsection 1 of NRS 449.101. Inspector Comments: Based on document review and interview the facility failed to provide upon admission the contact information for the Division where a resident, who had experienced prohibited discrimination, may file a complaint for 39 of 39 residents. Findings include: On 02/07/23 at 10:10 AM, the Administrator verbalized the State Agency complaint/non-discrimination information needed to be provided to the residents at the time of admission and confirmed no information was provided to the residents. Severity: 1 Scope: 3			
1540 SS= F	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 employee	1540	1. The facility was unable to meet cultural competency requirements due to financial constraints versus the cost of trainings. 2. The facility has found an online agency that provides affordable training. Currently the facility is working to get that training in compliance. 3. With the new requirements some staff members have had a cultural competency training and now meet guidelines. New hires are being offered the online training at time of hire. 4. Front office assistant/ care coordinator asst 5. 04/06/2023	04/06/2023

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	record review and interview, the facility failed to ensure 10 of 12 sampled employees had completed a cultural competency course approved by the Division of Public and Behavioral Health (Employee #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12). Findings include: The following employee records lacked documented evidence the employee had taken an approved cultural competency training course: -Employee #3 with a start date of 06/25/10, and a title of Wellness Director. -Employee #4 with a start date of 05/16/17, and a title of Activities Director. -Employee #5 with a start date of 06/20/22, and a title of Medication Technician. -Employee #6 with a start date of 03/20/12, and a title of Medication Technician. -Employee #7 with a start date of 12/28/22, and a title of Caregiver. -Employee #8 with a start date of 09/06/06, and a title of Housekeeper. -Employee #9 with a start date of 12/29/20, and a title of Medication Technician. -Employee #10 with a start date of 02/31/19, and a title of Caregiver. -Employee #11 with a start date of 12/28/22, and a title of Caregiver. -Employee #12 with a start date of 01/04/21, and a title of Housekeeper. On 02/07/23 at 3:01 PM, the Administrator verbalized only the Administrator and the Resident Care Coordinator had completed the approved cultural competency training course on 10/18/22. The Administrator confirmed no other employee had taken the training course due to the cost of the training. Severity: 2 Scope: 3			
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	1700	1. Placement determination form was misfiled for the new resident, and was removed from the chart for the admission from 2014. 2. Staff has been notified that placement determination forms must stay in the chart as it is considered a physician order for placement. 3. The forms were located and filed. Facility is creating a "do not remove" stamp for documents that must stay in the active chart	04/06/2023

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	examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate 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		for the entirety of stay. 4. Care coordinator/front office assistant 5. 04/06/2023	

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	Physician Assessment and Placement Determination for 2 of 10 residents (Resident #4, and #6). Findings include: Resident #4 Resident #4 was admitted to the facility on 05/29/14, with diagnoses including diabetes, chronic kidney disease and hypertension. Resident #4's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 02/07/23 at 3:23 PM, the Resident Care Coordinator confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #4. Resident #6 Resident #6 was admitted to the facility on 07/21/14, with a diagnosis including essential tremors, hypothyroid, gerd, high density lipoprotein, and depression. Resident #6's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 02/07/23 at 2:28 PM, the Resident Care Coordinator confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #6. Severity: 2 Scope: 1			