STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5192	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF SPARKS	2360 WINGFIELD HILLS DR, SPARKS, Nevada ,89436

(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 grading re-survey and complaint investigation conducted in your facility on 01/18/17. This State Licensure survey was conducted by the authority of NRS 449.0307 Powers of the Division of Public and Behavioral Health. The facility is licensed for 112 total Residential Facility for Group Category II beds with 80 beds which provide assisted living services for elderly and disabled persons, and or persons with chronic illness, and 32 beds for persons with Alzheimer's disease. The census at the time of the survey was 55 in assisted living and 10 in memory care, for a total of 65. Ten resident files and five employee files were reviewed. The facility received a re-survey grade of A. There were two complaints investigated. Complaint #NV00047632 with the following allegations could not be substantiated: Allegation #1: Resident not groomed adequately. Allegation #2: Lack of sufficient facility staffing. Allegation #3: Facility not clean. Allegation #4: Offensive odors. Allegation #5: Inappropriate level of care. Complaint #NV00047767 with the following allegations could not be substantiated: Allegation #1: Resident's transfer and discharge rights. Allegation #2: Resident's privacy not protected. The investigation for the allegations included: - Observations of residents, facility staff and a tour of the facility. - Review of resident files, employee files, past and current staffing schedules. - Interviews were conducted with seven residents, three caregivers, two medication technicians, the Care Coordinator and the Administrator. 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 deficiencies were identified:	0000		
0876 SS= D	449.2742(4) - Medication Administration NRS 449.0302 - NAC 449.2742 Administration of medication:	0876	Resident #3 - Ultimate User Agreement has been signed by facility (attached) Resident #5 - Ultimate User Agreement has	01/23/2017

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	Responsibilities of administrator, caregivers 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 controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure 1) ultimate user agreements were complete for 2 of 10 residents (Resident #3 and #5) and 2) the amount of medication prescribed by the physician was at a maintenance level and did not require an assessment for 1 of 10 residents (Resident #8). Findings include: Resident #3 was admitted on 07/12/15. The ultimate user agreement was signed and dated 06/30/15 by the resident indicating, the facility would manage the resident's medications. However, the form lacked documented evidence of the facility's signature and date. Resident #5 was admitted on 01/15/17. The ultimate user agreement was signed and dated 12/25/16 by the resident indicating, the facility would manage the resident's medications. However, the form lacked documented evidence of the facility's signature and date. Resident #8 was admitted on 10/14/15 with diagnoses including weakness, spinal stenosis and hypertension. On 01/18/17 in the afternoon, a review of the resident's Medication Administration Record (MAR) and physician order revealed, Tramadol 50 milligrams (MG), take one to two tabs by mouth every 6 hours as needed for pain. On 01/18/17 in the afternoon, the Assisted Living Coordinator acknowledged the medication orders and reported they were aware medications must not be prescribed with a range to require an assessment. On 01/18/17 in the afternoon, the Administrator acknowledged the deficiencies. This was a repeat deficiency from the 09/21/16 State Licensure survey. Severity: 2 Scope: 1		been signed by facility (attached) Move in Coordinator at MorningStar in Sparks will be responsible to make sure forms are signed. Files will be audited by Business Office and Coordinator prior to admission. Resident #8 - a DC order was faxed to the physician. Resident has not had pain and has not requested the PRN meds (copy attached). Wellness team to continue auditing MARS and med cart to ensure meeting regulations.	
0878 SS= D	NAC 449.2742(5)(6) - Medication / OTCs, Supplements, Change Order - NAC	0878	Assisted Living coordinator, Wellness Nurse and the Lead will audit the med cart and	01/23/2017

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	449.2742 Administration of medication: Responsibilities of administrator, caregivers 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 (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 1) medications were administered as prescribed for 1 of 10 residents (Residents #5) and 2) medications were on site to administer for 1 of 10 residents (Residents #8) Findings include: Resident #5 was admitted on 01/15/17 with		MARS once a week selecting resident randomly to ensure meeting regulations. Med Techs will be in-serviced on medication disbursement and MARS as per regulations. Resident #5: SOD was corrected on 1/23/2017. Copies and pictures are attached.	

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	diagnoses including osteoarthritis, hypertension, sleep apnea and hypoxemia. On 01/18/17 in the afternoon, a review of the resident's Medication Administration Record (MAR), physician orders and medications on site revealed the following: - The MAR and physician order read, Vitamin B-12 2,000 microgram (MCG) tabs, take one tab by mouth daily. However, the medication on site read, Vitamin B-12 1,000 MCG, take 2 tablets by mouth every day. The medication was not administered as prescribed. - The MAR and physician order read, Acetaminophen 500 milligrams (MG), take 2 tablets by mouth every 6 hours as needed (PRN) for pain. However, the medication on site read, MAPAP 325 MG tabs, take 2 tablets by mouth every 6 hours as needed for pain. The medication was not administered as prescribed. - The medication on site and physician order read, Tamsulosin HCL 0.4 MG capsule, take 1 cap by mouth every day for BPH. The Assisted Living Coordinator expressed, the medication was delivered to the facility in the evening on 01/17/17 with instructions to administer every morning. However, the MAR lacked documented evidence of the medication having been administered on 01/18/17. The medication was not administered as prescribed. Resident #8 was admitted on 10/14/15 with diagnoses including weakness, spinal stenosis and hypertension. On 01/18/17 in the afternoon, a review of the resident's MAR and physician order read, Tramadol 50 MG tabs, take 1-2 tabs by mouth every 6 hours as needed for pain. The medication was not on site to administer. The Assisted Living Coordinator expressed the medication was discontinued by the physician, however, the file lacked documented evidence of a discontinue order. On 01/18/17 in the afternoon, the Administrator acknowledged the deficiencies. This was a repeat deficiency from the 09/21/16 State Licensure survey. Severity: 2 Scope: 1			