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 _____	**01/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CESSABELLA RESIDENTIAL SUITE LLC #1	**8295 OPAL STATION DR, RENO, NEVADA ,89506**

(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 complaint investigation State Licensure survey completed in your facility on 01/02/2025. The survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly or disabled persons, and/or persons with mental illness, and/or persons with chronic illness, Category II residents. The census at the time of the survey was seven. There was one complaint investigated. The facility received a grade of B. Complaint #NV00072940 with the following allegations could not be substantiated due to lack of evidence: Allegation #1: A resident's medications were not on site. Allegation #2: A resident's Medication Administration Record did not show administration of medications. Allegation #3: A Caregiver lacked medication administration training and certification. The investigation into the allegations included: Observations of the environment, residents in their room and common spaces, and resident to staff interactions. Interviews with residents, including the residents of concern, caregivers and the Owner. Record review of physician assessments, facility assessments of activities of daily living, facility person-centered service plans, hospice care plans, medication administration records, personnel background checks, personnel caregiver and medication administration training and certifications. The investigation revealed the Administrator failed to ensure employees' fingerprints were submitted for a background check within 10 days of hire and upon the five year renewal, ensure employees maintained cardiopulmonary resuscitation and first aid certification, ensure residents had a person-centered	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EVA BELTEJAR Title: Owner Date: 02/04/2025

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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	service plan reviewed annually, properly stored medications, displayed the most current State survey placard and ensure residents had a physician placement determination upon admission (see Tag Y0104, Y0450, Y0515, Y0920, Y1045, and Y1700). 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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0104 SS= E	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 2 of 4 employees met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #3 and #4). Findings include: Employee #3 Employee #3 was hired by the facility as a Caregiver with a start date of 06/25/2018. Employee #3's personnel record documented evidence of fingerprinting to obtain a background check dated 04/05/2018. Employee #3's personnel record lacked documented evidence fingerprints were obtained for the five year renewal. The Nevada Automated Background System report dated 01/02/2025 at 7:11 AM, documented Employee #3's determination was eligible-expired. On 01/02/2025 at 12:44 PM, Owner verified Employee #3 did not have a background check on the employee's five year renewal date and confirmed Employee #3's background was currently expired. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 12/15/2024. Employee #4's personnel record lacked documented evidence of fingerprinting to obtain a background check for the facility. The Nevada Automated Background System report dated 01/02/2025 at 7:11 AM, lacked documented evidence of Employee #4 on the facility roster. On 01/02/2025 at 12:44 PM, the Owner confirmed Employee #4 did not have fingerprints and a background check for the facility. Severity: 2 Scope: 2	0104	1.Employee #3 and employee #4 has immediately completed fingerprinting and background check renewal. The facility will submit documentation to the Nevada Automated Background System (NABS) to reinstate eligibility and placed in files. 2. A tracking system has been implemented to monitor employee background check expiration dates. Alerts will notify management 90 days before expiration. All new hires will be required to complete fingerprinting before their official start date. The hiring process will not proceed until background check confirmation is received. 3.Office manager will conduct monthly audits of all employee personnel files to verify compliance with background check requirements. 4.The facility administrator is responsible for implementing and overseeing the corrective plan. 5. Completed on February 03, 2025 6. All pertinent documents have been uploaded. 7.A full audit of all employee personnel files will be conducted to identify any other staff with missing or expired background checks. Any identified deficiencies will be corrected immediately.	02/03/2025

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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 personnel record review and interview, the facility failed to ensure 1 of 4 employees had current cardiopulmonary resuscitation (CPR) and first aid training certification (Employee #3). Findings include: Employee #3 Employee #3 was hired by the facility as a Caregiver with a start date of 06/25/2018. Employee #3's personnel file contained CPR and first aid training certification dated 08/20/2022, with an expiration on 08/31/2024. Employee #3's personnel file lacked documented evidence of current CPR and first aid certification. On 01/02/2025 at 12:44 PM, the Owner confirmed Employee #3 lacked current CPR and first aid certification documentation. Severity: 2 Scope: 1	0450	1. Employee #3 was enrolled in the next available CPR and First Aid training course; Documentation of completion will be filed in Employee #3's personnel file. 2. Implement a procedure to ensure all employees have current CPR and First Aid certification as part of their initial orientation and ongoing employment requirements. Developed a process for reviewing all employee files to ensure compliance with CPR and First Aid certification requirements. Retained a consistent training course to provide group trainings for all staff. 3. The Facility Administrator will audits of employee files to ensure ongoing compliance with training certifications. All employees with lapse in training will be removed from floor. 4. The Facility Administrator is tasked with ensuring the Plan of Correction is implemented effectively and in a timely manner. 5. Completion Date: 02/10/2025 6. Documentation: all pertinent documentation uploaded. 7. A review of all current employee files will be conducted to identify any other employees lacking the required certifications. Any identified deficiencies will be corrected using the established corrective action process. Incorporate the training compliance procedure into the hiring process to prevent future occurrences of similar deficiencies.	02/10/2025
0515 SS= E	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of	0515	1. The facility has mediately completed and updated the person-centered service plans for Resident #1 and Resident #2 2. The person-centered service plan has be include in the quarterly file review checklist to monitor upcoming annual service plan reviews, ensuring timely completion before the due date. Staff has received re-training on service plan review requirements, with emphasis on regulatory compliance and	01/02/2025

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	this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to ensure a person-centered service plan was reviewed annually to address the facility's treatment of residents for 2 of 2 residents reviewed for service plans and due an annual review (Resident #1 and #2). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/08/2023, with diagnoses including hypertensive heart disease with heart failure, unspecified, unspecified osteoarthritis, major depressive disorder, chronic pain, insomnia, anxiety disorder. Resident #1's record documented a person-centered service plan dated 01/01/2024. Resident #1's clinical record lacked documented evidence of a person-centered service plan for 2025. Resident #2 Resident #2 was admitted to the facility on 03/19/2021, with diagnoses including chronic renal failure, hypokalemia, major depressive disorder, sedative dependence with current use, chronic kidney disease, stage 3, murmur, and essential hypertension. Resident #2's record documented a person-centered service plan dated 01/01/2024. Resident #2's clinical record lacked documented evidence of a person-centered service plan for 2025. On 01/02/2025 at 12:55 PM, the Owner confirmed the facility's person-centered service plans for Resident #1 and #2 had not been reviewed for 2025. Severity: 2 Scope: 2		documentation. 3. The Administrator or office manager will audit resident records monthly to ensure timely annual service plan reviews. 4.The facility office manger is responsible for implementation of plan of care. 5. Completion Date: 01/02/2025 6. Person-centered service plan for Residnet #1 and #2 has been uploaded. 7. The facility will conduct a comprehensive audit of all resident records to identify any additional residents whose person-centered service plans are overdue or missing. ?person centered service plan for Adrienne ?person centered service plan for Gloria	
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or	0920	1) The facility immediately discarded both Lorazepam containers as directed by the pharmacy. A new prescription for Lorazepam was obtained, properly stored in the refrigerator, and labeled with the opening date per manufacturer and pharmacy guidelines. 2) All medication storage areas were reviewed to ensure compliance with proper	01/02/2025

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	diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, record review, document review, and interview, the facility failed to store a resident's refrigerated medication properly and to properly label an open date of a medication for 1 of 5 sampled residents with medications reviewed (Resident #1) Findings include: Resident #1 Resident #1 was admitted to the facility on 07/08/2023, with diagnoses including hypertensive heart disease with heart failure, unspecified, unspecified osteoarthritis, major depressive disorder, chronic pain, insomnia, anxiety disorder. A physician's order dated 12/12/2024,documented Lorazepam 2 milligrams (mg)/milliliter (ml) oral suspension, take 0.25 ml under the tongue twice a day in the morning and bedtime, and 0.25 ml under the tongue or cheek every two hours as needed for agitation or jerking movement or shortness of breath. Resident #1's January 2025 Medication Administration Record (MAR) documented Lorazepam 2 mg/ml oral concentrate, take 0.25 ml by mouth twice a day for agitation and anxiety. The Lorazepam was located in Resident #1's un-refrigerated medication bin in the locked medication closet in the facility. The Lorazepam was unopened. The Lorazepam container had a yellow label to refrigerate, not to freeze. The Lorazepam		storage and labeling requirements. Staff responsible for medication management received immediate re-education on medication storage and labeling requirements. A medication labeling policy will be reinforced, requiring all opened medications to be dated immediately upon first use. 3) The facility administrator or office manager will conduct weekly audits of medication storage and labeling for three months, then monthly audits thereafter. Staff demonstrating non-compliance will undergo additional targeted training and disciplinary action if necessary. 4) The facility administrator is responsible for implementation of plan of improvement. 5) Completion Date: 01/02/2025 6) All pertinent documents uploaded. 7) A facility-wide audit of all refrigerated and labeled medications will be conducted to ensure compliance. Any improperly stored or unlabeled medications will be immediately corrected or replaced.	

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	container's fill date was dated 09/26/2024. A second Lorazepam container was opened and being used to administer to Resident #1. The second Lorazepam container had a white label to date when the container was opened for use. The Lorazepam container was not dated for the 90 day expiration period after opening. On 01/02/2025 at 11:28 AM, Owner confirmed first Lorazepam container was not refrigerated as per the label and second Lorazepam container was not dated when opened as per the label. The Owner verbalized not knowing the date when the second Lorazepam container was opened. The Owner spoke with the pharmacy and verbalized the Owner was directed by the pharmacy to discard both Lorazepam containers. Severity: 2 Scope: 1			
1045 SS= C	Placard - Display - NAC 449.27704 Placard: Issuance and display; failure to comply. (NRS 449.0302) 2. The administrator shall, within 24 hours after receipt of the placard, display or cause the placard to be displayed conspicuously in a public area of the residential facility. Inspector Comments: Based on observation and interview, the facility failed to display the B letter grade from the previous annual State Licensure survey dated 09/11/2024. Findings include: On 01/02/2025 at 9:35 AM, the A letter grade from the 01/03/2024 Complaint State Licensure survey was posted. The facility received a B letter grade from the 09/11/2024 State Licensure survey, however, this grade was not posted conspicuously in a public area of the residential facility. The B letter grade was uploaded to the online licensing system on 11/05/2024 from the 09/11/2024 State Licensure survey. On 01/02/2025 at 9:55 AM, the Owner confirmed the letter grade posted in the facility was from the survey conducted on 01/03/2024. Severity: 1 Scope: 3	1045	**1)** The facility immediately posted thecorrect B letter grade from the 09/11/2024 State Licensure survey in aconspicuous public area on 01/02/2025. The outdated A letter grade from the01/03/2024 survey was removed. Staff wereinformed of the requirement to post the most recent licensure survey grade. **2)** Theletter grade and all posted signs and notices have been included in the	01/02/2025

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			monthlyenvironment walk through checklist to ensure all items up to date and mostaccurate. Staff has been retrained to immediately post new grade once SODissued. **3)** The office manager will conduct quarterly audits to verify that thecorrect and most recent licensure grade is displayed. **4)** The facility administrator isresponsible for implementation of the plan of improvement. **5)Completion Date: 01/02/2025** **6)** Photo of new grade and settinguploaded. **7)** A facility-wide review of all required postings will be conducted toensure compliance with regulatory requirements. Any outdated, missing,	

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			orincorrect postings will be immediately corrected.	
1700 SS= E	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (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	1700	1) The facility immediately obtained a completed Physician Placement Determination for Resident #1 and corrected the incorrect placement determination for Resident #4. The facility contacted Resident #4's physician to clarify and update the placement determination to reflect the correct level of care. 2)The admission checklist will be reviewed to ensure all required physician documentation is completed before admission is finalized. The office manager and owner will review all new admissions to confirm accurate and complete placement determinations. All staff involved in admissions and record verification received re-training on the importance of correct placement documentation and regulatory compliance. 3) The office manager and owner will perform dual audit of newly admitted residents' records to verify placement determinations are completed accurately. Ongoing monthly audits will be conducted thereafter to ensure continued compliance. 4) The facility administrator is responsible for implementation of plan of care. 5) Completion Date: 01/30/2025 6) Updated Physician Placement Determinations for Resident #1 and Resident #4 have been uploaded. 7)A facility-wide audit of all current resident records will be conducted to ensure all Physician Placement Determinations are completed accurately.	01/30/2025

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	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 interview and clinical record review, the facility failed to ensure a standard placement determination was accurately completed by a provider upon admission for 2 of 5 sampled residents (Resident #1 and #4). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/08/2023, with diagnoses including hypertensive heart disease with heart failure, unspecified, unspecified osteoarthritis, major depressive disorder, chronic pain, insomnia, anxiety disorder. Resident #1's clinical record lacked documented evidence of a Physician Placement Determination for the facility. Resident #4 Resident #4 was admitted to the facility on 11/06/2024, with diagnoses including dementia with behavioral disturbances, psychosis, and failure to thrive in adult. Resident #4's clinical record documented of a Physician Placement Determination dated 11/05/2024, documented placement in an Alzheimer's locked facility. On 01/02/2025 at 10:42 AM, the Owner confirmed Resident #1 lacked a Physician Placement Determination for the facility and Resident #4's Physician Placement Determination was not correctly marked by the resident's physician for assisted living. Severity: 2 Scope: 2			