STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9346	A. BUILDING _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE ESTATES	**2907 N. MOUNTAIN ST., CARSON CITY, NEVADA ,89703**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted at your facility on 01/24/23. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for 60 Residential Facility for Group beds for elderly and disabled persons, 46 Category II residents and 14 Category II Alzheimer's Disease residents. The census at the time of the survey was 42. Fifteen resident files and ten 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. 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		
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	0074	Executive Director and Business' office manager completed an audit of employee files on 03/30/23. Employee # 1- The certificate for Elder abuse was sent to the previous Executive Director and was not given to Business' Office Manager, New Ed reached out to Administrator and was given his elder abuse certificate dated 01/06/23- Employee File Updated.	04/30/2023

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	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 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		Employee # 3 The training for Elder Abuse was provider to the Wellness Director on 02/12/23- employee file updated. Business' Office Manager and Executive Director will audit employee file once a month. Scheduled trainings, certifications & testing will continue to be monitored with audits and reminders to staff to completing trainings on time by due date.	

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	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 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 personnel file review and interview, the Administrator failed to ensure 3 of 10 employees received initial elder abuse training prior to beginning work at the facility and annually, thereafter (Employee #1, #2, and #3). Findings include: On 01/24/23, the Business Office			

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	Manager was provided the Personnel Check List to complete for 10 sampled employees. The Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 06/25/20. On 01/24/23, Employee #1's personnel file contained an elder abuse training dated 10/14/21; however, the personnel file contained no elder abuse training certificate for 2022, 101 days after annual training was required. Employee #2 Employee #2 was hired by the facility as Executive Director with a start date of 04/07/22. On 01/24/23, Employee #2's personnel file contained an initial elder abuse training dated 04/19/22, 12 days after start date. Employee #3 Employee #3 was hired by the facility as Wellness Director with a start date of 03/02/16. On 01/24/23, Employee #3's personnel file contained an elder abuse training certificate dated 01/14/22; however, the personnel file did not contain an elder abuse training certificate for 2023, 9 days after required. On 01/24/23 at 1:19 PM, the Business Office Manager provided the Attestation of Compliance form, signed and dated 01/24/23, confirming the Executive Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. This is a repeat citation from the 02/22/22 annual relicensure survey. Severity: 2 Scope: 2			

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0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the Administrator failed to ensure the interior premises were maintained. Findings include: On 01/24/23 at 9:54 AM, the blinds in Room B11 were broken and missing pieces. On 01/24/23 at 10:58 AM, a laundry room in the Bristlecone Building had a towel, a plastic hanger, and a plastic pitcher behind the washer and dryer. On 01/24/23 at 11:28 AM, a common bathroom in the Bristlecone Building had dirt built up in the shower. On 01/24/22 at 9:54 AM through 11:28 AM, the Director of Environmental Services acknowledged each concern. Severity: 2 Scope: 1	0178	Executive Director and Maintenance Director met on 04/12/23, we did a walk though of all houses and laundry rooms. The blinds in B-11 were replaced on: 01/25/23 Executive Director and Maintenance Director walked through all laundry rooms, we looked behind washer and dryers spoke about the importance of a clean and clear areas. Maintenance Director will be providing education at our all staff meeting on April 25th. Laundry area in question was cleared in the presence of the state surveyor on 01/23/23 Shower: cleaned by housekeeping daily and scoured weekly. Director of Maintenance cleaned and scoured the shower pointed out by inspector on 01/25/23. Maintenance Director will educate the housekeeping team and will be doing weekly walk throughs with his team every Friday to ensure a safe and clean environment.	04/12/2023
0250 SS= F	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure refrigerated food was labeled and resident utensils were stored properly with the potential to affect the facility census of 42. Findings include: Resident Utensils On 01/24/23 at 9:40, in the Aspen kitchen, a storage container with resident utensils were stored with the handles down. On 01/24/23 at 9:43, the Kitchen Supervisor verbalized all utensils for resident use	0250	Executive Director and Director of Dining did a walk through for each house/ kitchens. on April 11th. Dinning Director provided onsite correctional education to the scheduled Caregivers/Med Techs regarding the utensils and the handles facing up. Executive Director will create a sign and place in all kitchens. Education will be provided at the all staff meeting on April 25th. Daily reminders are added to the daily list for Dining Director to monitor. All Refrigerators/ food storage area will be audited every Monday, Wednesday and Friday to ensure food is covered properly and properly labeled.	04/11/2023

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	should be stored handle up so the staff did not handle the eating end of the utensil. On 01/24/23 at 9:30 AM, located in the kitchen refrigerator and cabinets, the following food items were identified as not stored properly by being unsealed, unlabeled, or undated. Bristlecone kitchen: - a one quart container of peaches was not dated/labeled. - a container of four oranges cut into slices was not dated/labeled. Aspen kitchen: - a one quarter full pitcher of orange colored juice was not dated/labeled - three large bags of opened tortilla chips in lower cabinet were unsealed, unlabeled, and undated. On 01/24/23 at 9:33, the Kitchen Supervisor confirmed the food items lacked a date and identification labeling and verbalized all food items should have a date and identification label. The facility policy titled "Kitchen Sanitation Standards," dated 05/2020, documented all food must be wrapped, identified and dated when placed in storage. The facility policy titled "Storage/Inventory," dated 05/2020, documented properly cover, reseal, and date any food product container after opening, or when storing leftover cooked/prepared food in the freezer and confirm, or add, a label that properly identifies the food. Cooked, or prepared food must be labeled with the date placed in the refrigerator or freezer. Severity: 2 Scope: 3			

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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 record review and interview, the facility failed to ensure employees obtained timely first aid and cardiopulmonary resuscitation (CPR) training for 2 of 10 sampled employees working at the facility greater than 30 days (Employee #1, and #9). Findings include: On 01/24/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. The Business Office Manger provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 06/25/20. Employee #1's employee file contained a first aid and CPR training certificate dated 01/2020 and 05/2022, four months after required. Employee #9 Employee #9 was hired by the facility as Resident Assistant with a start date of 12/06/22. Employee #9's employee file contained a first aid and CPR training certificate dated 01/26/23, 20 days after required. On 01/24/23 at 1:19 PM, the Business Office Manager provided the Attestation of Compliance form, signed and dated 01/24/23, confirming the Executive Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0450	Executive Director and Business' office manager completed audit on 03/30/23. Scheduled training,certifications & testing will continue to be monitored with audits andreminders to staff to completing trainings on time by due date. Audits to be performedonce a month with executive director. The 3rd of every month.	03/30/2023

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0451 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure expired medications in first aid kits were destroyed for 2 of 4 first aid kits. Findings include: On 01/24/23 at 2:00 PM, the first aid kit in the Bristlecone Building contained Pennsaid diclofenac 40 mg expired 11/2020. On 01/23/23 at 2:00 PM, the Director of Environmental Services verbalized the medications were expired and removed them from the first aid kits. Severity: 2 Scope: 1	0451	Executive Director and Maintenance Director reviewed SOD on 03/23/23. A audit was done on 03/23/23 in the presence of the Executive Director. First aid kits were in compliance. on 1/24/23 Maintenance Director removed the expired peensaid diclofenac in the presence of the state inspector. they were later destroyed with the Wellness Director. Monthly audits will be performed on all of first aid kits the 3rd of every month with executive director.	03/23/2023
0620 SS= F	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 9 of 9 residents receiving skilled nursing services (Resident #1, #3, #6, #7. #8, #13, #15, #16, and #17. Findings include: Resident #1 Resident #1 was admitted to the facility on 10/07/21, with a diagnosis dementia. Resident #3 Resident #3 was admitted to the facility on 08/22/22, with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side. Resident	0620	Executive Director and Wellness Director reached out to Hospice and Home health agencies requesting documentation/schedules needed to get waivers on each patient. Audit concluded on 04/07/23 all hospice and home health residents either have a waiver or it's pending approval from the state website. All have or will be uploaded in PointClickCare. Wellness Director and Executive Director will ensure we have following; POC for a Hospice care or a home health agency and the plan of care including certification period, doctors orders and signatures, medical assignments and skilled nurse's scheduled upon move in and will be submitted to the state website prior to resident moving in. Attached is the Waivers for our current residents.	04/07/2023

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	#6 Resident #6 was admitted to the facility on 05/11/22, with a diagnosis of chronic obstructive pulmonary disease. Resident #7 Resident #7 was admitted to the facility on 08/04/22, with a diagnosis of senile degeneration. Resident #8 Resident #8 was admitted to the facility on 08/02/21, with a diagnosis of dementia. Resident #13 Resident #13 was admitted to the facility on 04/13/21, with a diagnosis of pulmonary embolism. Resident #15 Resident #15 was admitted to the facility on 01/09/23, with a diagnosis of anxiety disorder. Resident #16 Resident #16 was admitted to the facility on 04/19/21, with a diagnosis of Alzheimer's disease. Resident #17 Resident #17 was admitted to the facility on 11/02/20, with a diagnosis of congestive heart failure. On 01/24/23 at 3:24 PM, during a phone call, the Wellness Director the facility had residents receiving skilled nursing care through home health and hospice agencies. The Wellness Director explained the Wellness Director was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The Wellness Director confirmed the facility had not submitted waivers to the State Agency to admit or retain residents receiving skilled nursing care. Severity: 2 Scope: 3		Resident #1, 8, 13, 15 are no longer in the facility.	

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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 record review and interview, the facility failed to ensure an annual history and physical was completed timely for 1 of 15 sampled residents (Resident #13). Resident #13 Resident #13 was admitted to the facility on 04/13/21, with diagnoses including pulmonary embolism, peripheral vascular disease, and heart disease. Resident #13's record documented an initial History and Physical dated 04/07/21, and an annual History and Physical dated 09/14/22, approximately five months late. On 01/24/23 at 4:12 PM, the Executive Director verbalized the History and Physical was completed late for Resident #13. Severity: 2 Scope: 1	0859	Executive Director and Wellness Director completed an audit for annual H&P's on April 13th . The 3rd week of each month the Wellness Director will audit H&P's to ensure we are current and scheduling upcoming annuals. The Wellness Director will also create a spreadsheet by end of this month and share with the Executive Director for better monitoring.	04/13/2023

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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 facility failed to ensure a resident had a valid Ultimate User Agreement authorizing the facility to store and administer medications for 1 of 15 sampled residents (Resident #8). Resident #8 Resident #8 was admitted to the facility on 08/02/21, with diagnoses including dementia, altered mental status, and atrial fibrillation. Resident #8's clinical record documented an Ultimate User Agreement Request and Authorization for Medical Supervision and Assistance, dated 07/20/21. The Ultimate User Agreement documented the resident requested and authorized the facility to possess and administer medications and the resident declined to have the facility retain and supervisor the administration of medication. On 01/24/23 at 2:50 PM, a Medication Technician confirmed the facility stored and administered medications for Resident #8. On 01/24/23 at 4:10 PM, the Executive Director confirmed the Ultimate User Agreement was invalid due to the form documenting Resident #8 authorized and declined the facility to possess and administer medications. Severity: 2 Scope: 1	0876	ExecutiveDirector and Director of Business' development audited move in packet 04/11/23 Admissions/ Director of Business Development hasthe Ultimate User Agreement form and Authorization for medical supervisionare in the move in packet to be completed by responsible partyeither before or on admission day. Executive Director educated Director ofBusiness development on the importance of having this completed form completedand filed. The Executive Director will audit move in packetsonce a month to ensure that all documents has been completed and filed.	04/11/2023
0878 SS= E	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	0878	Wellness Director and Executive Director went over Pharmacy review that was completed on 03/03/23. A few patients are no longer with us. Attached are corrections to our , missing and discontinued medications. I have a meeting on May 25th	04/12/2023

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	9346	A. BUILDING _____ B. WING _____	01/24/2023

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	resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must 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 clinical record review and interview, the Administrator failed to ensure medications were on-site to administer as prescribed for 5 of 15 sampled residents (Resident #1, #2, #7, #13 and #15) and an over-the-counter medication label contained a physician name for 1 of 15 sampled residents (Resident #15). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/07/21, with diagnoses including cough, insomnia and Alzheimer's disease. Resident #1's January 2023 Medication		2023 with the liaison for Sierra Pharmacy about having more than med chart audits compared to every six month pharmacy audit/reviews. Resident #1- Passed Away Resident # 2 -Passed Away Resident #7- Medication Robafen DM Liquid was discontinued on 03/03/23. Resident #13- Banophen was discontinued on 03/10/23, Codeine/guaifenesin was discontinued on 01/23/23, Hyoscyamine was ordered om 02/20/23 and delivered on 02/21/23, Lactulose discontinued on 04/12/23 ,prochlorper was ordered on 01/31/23, Promethegan refilled 04/12/23, gentle laxative d/c request sent on 04/12/23. PRN meds have been ordered attached updated med list. Resident #15 Passed Away Wellness Director will assign Med Tech leads to audit Med Carts daily, report to her any missing medication or medication needing refill in 10 days to be given to Wellness Director and Wellness Director will send over to pharmacy for refills. Executive Director will be meeting with Sierra Pharmacy Liaison on May 25th to help educate Director with tools for training and compliance.	

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	Administration Record (MAR) documented Mucinex Fast-Max DM Max 5 milligram (mg)-100mg, take 20 mililiters by mouth every four hours as needed(PRN) for persistent cough and chest congestion. The PRN medication was not available on site. Resident #1's physician order dated 11/16/22, documented Mucinex Fast-Max DM Max 5 milligram (mg)-100mg, take 20 mililiters by mouth every four hours as needed for persistent cough and chest congestion. On 01/23/23 at 12:43 PM, a Caregiver confirmed the facility lacked Resident #1's PRN Mucinex Fast-Max DM. Resident #2 Resident #2 was admitted to the facility on 05/24/22, with diagnoses including chronic obstructive pulmonary disease, and diabetes Resident #2's January 2023 MAR documented Combivent Respimat aerosol solution 20-100, one inhalation orally every 4 hours as needed for respiratory failure. Rinse mouth after use. The PRN medication was not available on site. Resident #2's physician order dated 06/13/22, documented Combivent Respimat aerosol soution 20-100 MCG/ACT, one inhalation inhale orally every four hours as needed for respiratory failure. Rinse mouth after use. On 01/23/23 at 12:43 PM, a Caregiver confirmed the facility lacked Resident #2's PRN Combivent inhaler. Resident #7 Resident #7 was admitted to the facility on 08/04/22, with diagnoses including chronic obstructive pulmonary disease, senile degeneration of brain and unspecified dementia with behavioral disturbance. Resident #7's MAR dated January 2023, documented Robafen DM Liquid 20-200 mg. Take 10 ml by mouth every four hours as needed for persistent cough and chest congestion. Resident #7's physician order dated 11/21/22, documented Robafen DM Liquid 20-200 mg. Take 10 ml by mouth every four hours as needed for persistent cough and chest congestion. On 01/24/23 at 1:43 PM, during a medication review, Resident #7's Robafen DM Liquid could not be located onsite. On 01/24/23 at 1:43 PM, the Medication Technician confirmed Resident #7's Robafen DM Liquid was not onsite and available to administer to the resident. The Medication Technician verbalized not			

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	knowing how long the medication had been out and the facility was required to order the medication from the pharmacy 10 days before the medication was to run out. Resident #13 Resident #13 was admitted to the facility on 04/13/21, with diagnoses including pulmonary embolism, peripheral vascular disease, and heart disease. Resident #13's MAR dated January 2023 documented Banophen 25 mg capsule. Take one capsule by mouth three times daily as needed for rash/itching. Resident #13's physician order dated 05/03/22, documented Banophen 25 mg capsule. Take one capsule by mouth three times daily as needed for rash/itching. On 01/24/23 at 2:40 PM, during a medication review, Resident #13's Banophen could not be located onsite. Resident #13's MAR dated January 2023 documented codeine/guaifenesin solution 10-100/5. Take 5 ml by mouth every four hours as needed for cough. Resident #13's physician order dated 12/09/22, documented codeine 10 mg/guaifenesin 100 mg/5 ml. Take 5 ml by mouth every four hours as needed for cough. On 01/24/23 at 2:37 PM, during a medication review, Resident #13's codeine/guaifenesin solution could not be located onsite. Resident #13's MAR dated January 2023 documented gentle laxative suppository 10 mg. Unwrap and insert one suppository per rectum once daily as needed for no bowel movement in three days (Registered Nurse (RN) to place). Resident #13's physician order dated 01/26/22, documented gentle laxative suppository 10 mg. Unwrap and insert one suppository per rectum once daily as needed for no bowel movement in three days (RN to place). On 01/24/23 at 2:37 PM, during a medication review, Resident #13's gentle laxative suppository could not be located onsite. Resident #13's MAR dated January 2023 documented hyoscyamine sublingual 0.125 mg tablet. Take one tablet by mouth/sublingual every four hours as needed for retained secretions. Resident #13's physician order dated 01/26/22, documented hyoscyamine sublingual 0.125 mg tablet. Take one tablet by mouth/sublingual every four hours as needed for retained secretions. On 01/24/23			

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	at 2:39 PM, during a medication review, Resident #13's hyoscyamine could not be located onsite. Resident #13's MAR dated January 2023 documented lactulose solution 10 gram (gm)/15 ml. Take 30 ml every three days as needed for no bowel movement in three days. Mix with 2 ounces cranberry juice if needed. Resident #13's physician order dated 08/18/22, documented lactulose solution 10 mg/15 ml. Take 30 ml every three days as needed for no bowel movement in three days. Mix with 2 ounces cranberry juice if needed. On 01/24/23 at 2:40 PM, during a medication review, Resident #13's lactulose could not be located onsite. Resident #13's MAR dated January 2023 documented prochlorper 10 mg tablet. Give one tablet every six hours as needed for nausea and /or vomiting. Resident #13's physician order dated 01/26/22, documented prochlorper 10 mg tablet. Give one tablet every six hours as needed for nausea and /or vomiting. On 01/24/23 at 2:36 PM, during a medication review, Resident #13's prochlorper could not be located onsite. Resident #13's MAR dated January 2023 documented Promethegan 25 mg suppository. Administer by nurse only. Unwrap and insert one suppository per rectum every six hours as needed for nausea. Resident #13's physician order dated 07/28/22, documented Promethegan 25 mg suppository. Administer by nurse only. Unwrap and insert one suppository per rectum every six hours as needed for nausea. On 01/24/23 at 2:37 PM, during a medication review, Resident #13's Promethegan could not be located onsite. On 01/24/23 at 2:41 PM, the Medication Technician confirmed Resident #13's Banophen, codeine, gentle laxative, hyoscyamine, lactulose, prochlorper and Promethegan was not onsite and available to administer to the resident. The Medication Technician explained the medications were administered as needed and had not been requested by the resident. Resident #15 Resident #15 was admitted to the facility on 01/09/23, with diagnoses including anxiety, pain, and cerebellar infarction. Resident #15's MAR dated January 2023 documented Anucort-			

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	HC 25 mg suppository. Unwrap and insert one suppository per rectum twice daily as needed for hemorrhoid pain. Resident #15's physician order dated 01/23/23, documented Anucort-HC 25 mg suppository. Unwrap and insert one suppository per rectum twice daily as needed for hemorrhoid pain. Resident #15's MAR dated January 2023 documented Tucks medicated cooling pads. Apply one pad to skin six times daily as needed for hemorrhoid pain. Resident #15's physician order dated 01/23/23, documented witch hazel 50% topical pads. Apply one pad to skin six times daily as needed for hemorrhoid pain. On 01/24/23 at 2:42 PM, the Medication Technician confirmed Resident #15's Anucort and Tucks medicated pads were not on site. The Medication Technician explained the medications were administered as needed and had not been requested by the resident. Over The Counter Medications Resident #15's MAR dated January 2023 documented acetamin 500 mg tablet. Take one tablet by mouth at bedtime for pain. Resident #15's physician order dated 01/23/23, documented acetaminophen 500 mg capsule. Take one capsule at bedtime for pain. Resident #15's over the counter acetaminophen medication bottle lacked the name of the ordering physician. Resident #15's MAR dated January 2023 documented Excedrin extra strength 250-250-65 mg. Take two tablets in the morning. Resident #15's physician order dated 01/23/23, documented Excedrin extra strength 250-250-65 mg. Take two tablets by mouth in the morning. Resident #15's over the counter Excedrin medication bottle lacked the name of the ordering physician. Resident #15's MAR dated January 2023 documented Ibuprofen 200 mg. Take three tablets by mouth at bedtime for pain. Resident #15's physician order dated 01/23/23, documented Ibuprofen 200 mg. Take one table by mouth at bedtime for pain. Resident #15's over the counter Ibuprofen medication bottle lacked the name of the ordering physician. Resident #15's MAR dated January 2023 documented vitamin D3 5000-unit tablets. Take one tablet by mouth once daily for			

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	supplement. Resident #15's physician order dated 01/23/23, documented vitamin D3 5000-unit tablets. Take one tablet by mouth once daily for supplement. Resident #15's over the counter vitamin D3 medication bottle lacked the name of the ordering physician. On 01/24/23 at 2:05 PM, the Medication Technician confirmed the over the counter medications lacked the ordering physician's name. Severity: 2 Scope: 2			
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 Activities of Daily Living (ADL) Assessment was completed upon admission for 8 of 15 sampled residents (Resident #2, #6, #15, #3, #11, #12, #7, and #9). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/24/22 with diagnoses including diabetes and chronic obstructive pulmonary disease. Resident #2's initial ADL Assessment was dated 07/07/22, however, was 44 days after Resident #2's admission. Resident #6 Resident #6 was admitted to the facility on 05/11/22 with diagnoses including chronic	0938	Executive Director and Director of Business' development audited ADL Record book 04/11/23. Attached is a ADL for the resident in question. Admissions/ Director of Business Development has the ADL form in the move in packet to be completed by reasonable party either before or on admission day. Executive Director educated Director of Business development on the importance of having the ADL form completed and filed. Executive Director will audit move in ADL book once a month to ensure the ADL has been completed and filed. Attached are the signed ADL's for the residents whom still live at the facility.	04/11/2023

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	obstructive pulmonary disease, diabetes mellitus and arthritis. Resident #6's initial ADL Assessment was dated 05/20/22, however, was 10 day after Resident #6's admission. Resident #15 Resident #15 was admitted to the facility on 01/09/23 with a diagnosis of anxiety disorder. Resident #15's clinical record lacked an initial ADL Assessment. On 01/24/23 at 2:26 PM, the Executive Director confirmed an initial ADL Assessment was not completed upon admission for Residents #2, #6 and #15. Resident #3 Resident #3 was admitted to the facility on 08/22/22, with the diagnoses including chronic kidney disease III, hemiplegia and hemiparesis following a cerebral infarction affecting left dominant side, and dysphagia. Resident #3's initial ADL Assessment was dated 08/06/22, however, no staff signature was present on the assessment to determine validity and accuracy of the assessment. Resident #11 Resident #11 was admitted to the facility on 05/07/22, with a diagnosis of severe advanced dementia. Resident #11's initial ADL Assessment was dated 04/19/22, however, no staff signature was present on the assessment to determine validity and accuracy of the assessment. Resident #12 Resident #12 was admitted to the facility on 05/04/22, with diagnoses including diabetes mellitus, cerebral infarction without residual deficits, and atrial fibrillation. Resident #12's initial ADL Assessment was dated 04/29/22, however, no staff signature was present on the assessment to determine validity and accuracy of the assessment. On 01/24/23 at 4:12 PM, the Executive Director confirmed the ADL Assessments for Resident #3, #11, and #12 lacked staff signatures, rendering the ADL Assessments invalid. Resident #7 Resident #7 was admitted to the facility on 08/04/22, with diagnoses including chronic obstructive pulmonary disorder, senile degeneration of brain and unspecified dementia with behavioral disturbance. Resident #7's initial ADL Assessment was dated 07/12/22, however, no staff signature was present on the assessment to determine validity and accuracy of the assessment. Resident #9 Resident #9 was admitted to the facility on 12/20/22, with a diagnosis of dementia with behavioral			

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	disturbance. Resident #9's clinical record lacked documented evidence an initial ADL assessment was completed upon admission to the facility. On 01/24/23 at 2:15 PM, the Administrator verbalized ADL assessments were to be completed upon admission, for every resident, and annually thereafter. The ADL assessments would be initialed by a staff member confirming the accuracy of the assessments completed. The Administrator confirmed Resident #7's ADL assessment lacked staff signature to determine the validity and accuracy of the assessment. The Administrator confirmed Resident #9 did not have an initial assessment completed. Severity: 2 Scope: 3			
0999 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: (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 toxic substances were inaccessible to residents housed in the memory care unit for 2 of 9 rooms occupied by residents. Findings include: On 01/24/23 at 9:26 AM, the following toxic items were unsecured in Room 5: - a 16-ounce container of Cetaphil moisturizing lotion On 01/24/23 at 9:34 AM, the following toxic items were unsecured in Room 8: - two 8-ounce containers of Soothe and Cool Fresh skin cream - a 3.4-ounce container of Paco Rabanne eau de toilet - a container of Arm & Hammer Ultra Max 3-in-1 body wash/shampoo/conditioner - an 11-ounce container of Dial Complete liquid antibacterial hand soap - an 80-drop package of Halls Relief cough drops - a 4.5-ounce container of adult Aim toothpaste On 01/24/23 at 9:26 AM through 9:34 AM, the Director of Environmental Services confirmed the presence of unsecured toxic substances in rooms 5 and 8. Severity: 2 Scope: 2	0999	ExecutiveDirector and Maintenance Director did a walk through of the memory care unit on04/12/23. In the locked med room each patient has a cubby that toxic items areto be secured in. Education was provided to on shift staff. All staff meeting is scheduled for April 25th andwill discuss will all staff on the importance of always storing personal toxicitems in Cubbies when not in use by the care team. The Maintenance Director will include toxic itemson his daily walk through list to ensure all residents are safe and itemsare stored appropriately.	04/12/2023

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1305 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.] 2. 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 shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. Inspector Comments: Based on observation and interview, the facility failed to post a current nondiscrimination statement prominently in the facility and include on any Internet website used to market the facility. Findings include: On 01/24/23 at 10:01 AM, the facility lacked a current nondiscrimination statement for residents and the public to view. On 01/24/23 at 10:01 AM, the Business Office Manager acknowledged a nondiscrimination statement had not been posted in any common public area of the facility. Severity: 1 Scope: 3	1305	Business' Office Manager posted non discrimination statement on 03/30/23. Executive Director will add to daily walk through list to ensure all required is posted.	03/30/2023

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SKYLINE ESTATES	2907 N. MOUNTAIN ST., CARSON CITY, NEVADA ,89703

(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
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 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 prominently in the facility the State contact information to file a complaint for a resident who may have experienced prohibited discrimination. Findings include: On 01/24/23 at 10:01 AM, the facility lacked posted documentation of the State contact information to file a complaint for any resident who may experience discrimination. On 01/24/23 at 10:01 AM, the Business Office Manager acknowledged the State's contact information had not been posted in any common public area of the facility to inform residents where to file a complaint of discrimination. Severity: 1 Scope: 3	1310	Business'Office Manager posted a nondiscrimination statement on 03/30/23. The Executive Director will add to daily walk-throughlist to ensure all required is posted.	03/30/2023