STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9423	A. BUILDING _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE ESTATES	**2765 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 30 Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was 19. Ten 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 of older persons before a license to operate	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. Employee # 3 The training for Elder Abuse	03/30/2023

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	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 violations of NRS 200.5091 to 200.50995,		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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	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 Manager was provided the Personnel			

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	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. 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 re-licensure survey. Severity: 2 Scope: 2			

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0220 SS= D	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on observation and interview the facility failed to ensure a dryer lint trap was free from excessive lint. Findings include: On 01/24/23 at 11:10 AM, a dryer in the Cedar building had a thick layer of lint on the lint trap. On 01/24/23 at 11:10 AM, the Director of Environmental Services verbalized lint should be removed from the dryer after each use. Severity: 2 Scope: 1	0220	Executive Director and Maintenance Director met on 03/23/23 to review SOD. Maintenance staff checks for excessive lent on and around all dryers once weekly- every Monday. It is posted in Laundry area to clean out lint traps before and after each use, effective 3/30/23. Maintenance Director cleared out lint traps in the presence of State inspector on 1/24/2023.	03/23/2023
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, interview and document review, the facility failed to ensure dented cans were not stored with non-dented	0250	Executive Director and Dinning director did a walkthrough of the storage area on 03/30/23. Dented cans are being placed in a crate marked "dented cans" until they can be returned or credited back to facility, once either happens they will be disposed of weekly. Dinning Director made call to us foods complaining of the dented cans if this continues on next shipment we will look for another vendor to order canned goods. All dinning staff made aware in a dinning meeting on 03/30/23 no dented cans are	03/30/2023

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	canned food inventory, refrigerated food was labeled and discarded by use-by date, staff were using gloves in the preparation of food, cleaning towels were kept in sanitizing solution, and kitchen sanitizer was being used at the correct strength with the potential to affect the facility census of 19. Findings include: Dented Cans On 01/24/23 at 8:58 AM, in the dry storage room inventory of canned foods, there was the following dented cans: - one 51 ounce can of cream of mushroom - two 6 pound 8 ounce cans of vegetables for stew On 01/24/23 at 9:00 AM, the Cook confirmed the dented cans were stored in the dry food storage inventory of cans to be used for cooking for the residents. The Kitchen Supervisor verbalized dented cans needed to be removed from inventory because they could cause botulism to the residents. The facility policy titled "Food Preparation/Handling," dated 05/2020, documented never use canned goods that are damaged, bulging, or rusted. The facility "Pre-Survey Tips," undated, documented dry storage items sealed. No dented or dusty can goods. Labeling and Discarding On 01/24/23 at 9:00 AM, in the walk-in refrigerator, the following foods were identified: - three one-half gallon containers of milk with a use-by date of 12/30/22 - an approximate four inches square piece of cake was in a pan uncovered, unlabeled and undated. On 01/24/23 at 9:02 AM, the Kitchen Supervisor confirmed the milk should have been discarded on previous date. The Kitchen Supervisor confirmed the cake should have been covered and labeled. Staff Preparing Food On 01/24/23 at 4:35 PM, the Kitchen Supervisor was observed cutting sandwiches on a cook tray without wearing gloves. On 01/24/23 at 4:36 PM, the Kitchen Supervisor confirmed the Kitchen Supervisor was not wearing gloves while cutting sandwiches for the residents' consumption and verbalized kitchen staff were to wear gloves when preparing food for residents. On 01/24/23 at 4:38 PM, a Resident Assistant (RA) was observed inside the kitchen area preparing resident dinner plates from the hot holding serving trays without wearing a hair net. The RA verbalized a hair net was not necessarily		able to be used to preparing food. they were also made aware that dented cans are to be placed in the marked crate and then to notify dinning director. Executive Director and Dinning Director to do walk through on stage area every Thursday after food delivery.	

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	required since the RA was not preparing food and confirmed the RA was inside the kitchen area preparing resident dinner plates from the hot holding serving trays. The facility policy titled "Food Preparation/Handling," dated 05/2020, documented Food Safety, team members use food preparation safety to avoid cross-contamination - do not let hands touch prepared food. The facility "Dress Code Rules," dated 03/2020, documented hair net must be worn. On 01/24/23 at 4:39 PM, the Executive Director verbalized the staff in the kitchen area were expected and trained to wear hair nets or caps as required by state regulations. Sanitation On 01/24/23 at 9:06 AM, a cleaning cloth was observed sitting in an empty sanitizer bucket. On 01/24/23 at 9:06 AM, the Kitchen Supervisor verbalized the sanitation bucket should be filled with sanitizer and cleaning cloths should be kept in the bucket filled with sanitizer and ready to use. On 01/24/23 at 9:12 AM, the Kitchen Supervisor filled the bucket with sanitizer and verbalized the dispenser had not dispensed the sanitizer at the correct strength per the testing strip. The testing strip indicated 100 parts per million (ppm). The Kitchen Supervisor verbalized the correct strength was 400 ppm. On 01/24/23 at 10:22 AM, the Kitchen Supervisor verbalized speaking to the Dining Director and the Dining Director informed the Kitchen Supervisor the facility had been waiting for two weeks for parts for the sanitizer dispenser to be repaired and the workman was on their way to the facility today to repair the dispenser. The facility policy titled "Cleaning/Sanitation," dated 05/2020, documented use sanitizer and water to prepare and use a cleaning solution as follows: prepare the solution properly at recommendation parts per million, usually 400 ppm. On 01/24/23 at 9:05 AM, in the in-kitchen refrigerator the following foods were identified: - four sliced oranges uncovered, unlabeled, and undated. - 1 quart of diced peaches uncovered, unlabeled and undated. - 15 hard boiled eggs uncovered, unlabeled and undated. - 1 quart of diced celery uncovered, unlabeled and undated. On 01/24/23 at 9:10 AM, the Kitchen			

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	Supervisor confirmed all of these food items should have been covered, labeled, and dated properly before being stored in the refrigerator. The facility policy titled "Storage/Inventory," dated 05/2020, documented properly cover, reseal, and date and food product after opening, or when storing leftover cooked/prepared food in the refrigerator and add a label that properly identifies the food. 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 trainings, certifications & testing will continue to be monitoredwith audits and reminders to staff to completing trainings on time by due date.Audits to be performed once a month with executive director. The 3rd of everymonth.	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 1 of 1 first aid kits. Findings include: On 01/24/23 at 1:50 PM, the first aid kit in the Cedar Building contained Pepto Bismol tablets expired 12/02/21. On 01/23/23 at 1:50 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 Pepto Bismol in the presence of the state inspector. they were later destroyed with the Wellness Director. Monthly audits will be preformed on all of first aid kits the 3rd of every month with executive director.	03/23/2023

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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 2 residents receiving skilled nursing services (Resident #9 and #11). Findings include: Resident #9 Resident #9 was admitted to the facility on 11/24/19, with a diagnosis of severe confusion/memory loss. Resident #11 Resident #11 was admitted to the facility on 11/15/21, with a diagnosis of multiple system atrophy. 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 retain residents receiving skilled nursing care. Severity: 2 Scope: 1	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.	04/07/2023

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0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 01/24/23 at 11:06 AM, Room C-5 contained four e-sized oxygen cylinders stored against a wall, unsecured. On 01/24/23 at 11:06 AM, the Director of Environmental Services confirmed the oxygen tanks were unsecured and verbalized oxygen tanks should be kept in a rack. Severity: 2 Scope: 1	0690	Executive Director and Maintenance Director walked the buildings on 03/24/23 of all residents using oxygen machines. All were stored correctly. on 01/23/23 Maintenance Director ensured all oxygen tanks were properly stored in metal rack by end of day on 01/23/23. Maintenance Director and Executive Director will we doing weekly walk arounds on every Monday of each week. Following a list to be audited including proper storage of oxygen tanks. This will also be on the agenda for the all staff meeting.	03/24/2023

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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 clinical record review, document review and interview, the Administrator failed to ensure a six-month pharmacy review had been completed for 1 of 10 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 01/18/17, with diagnoses including chronic anticoagulation, hypertension and benign prostatic hyperplasia. Resident #2's clinical record documented a six month pharmacy profile review dated 09/08/22, one month late. Resident #2's clinical record lacked documentation of a six month pharmacy profile review in March 2022. On 01/24/23 at 2:05 PM, the Executive Director confirmed Resident #2's clinical record lacked documentation of a March 2022 six month pharmacy profile review and verbalized the reviews needed to be completed every six months. Severity: 2 Scope: 1	0870	Executive Director and Wellness Director audited all patient files on 04/06/23. Executive Director and Wellness Director will audit patient files every month, 3rd of every month. Included in audit will be pharmacy review. Faxing has not been successful with communication with physicians, Executive Director will schedule an appointment with physicians to review pharmacy reviews and signatures. Sierra Pharmacy is scheduled to come out again in September 2023, day to be determined.	04/06/2023

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0874 SS= D	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, document review and interview, the Administrator failed to notify a resident's physician of the pharmacist's recommendation for 1 of 10 sampled residents in the facility longer than six months requiring a medication profile review with a pharmacist's recommendation (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/16/21 with diagnoses including dementia with behavioral disturbances, atrial fibrillation, hyperlipidemia and essential hypertension. Resident #1's clinical record documented a medication profile review dated 03/14/22, with the following recommendation: - Comment: - Limit Tylenol to 3,000 milligrams per day. Resident #1's clinical record documented the recommendation had been communicated to Resident #1's physician on 03/22/22, five days late. On 01/24/23 at 2:00 PM, the Executive Director confirmed the physician notification occurred after 72 hours and verbalized the resident's physician should be notified of any recommendation from the six month pharmacy profile review within 72 hours. Severity: 2 Scope: 1	0874	Executive Director and Wellness Director Audited Pharmacy reviews Physician reviews/signature on 04/06/23. All files are in compliance with Physician and Pharmacy reviews/signatures. Wellness Director or Executive Director will hand deliver to physician with any changes and updates for review and signature. Spoke with the Pharmacy Liaison for Sierra Pharmacy she has also offered to help with communication with the physicians for the buildings, a meeting if set up for May 2nd to discuss further options.	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	0878	Executive Director and Wellness Director completed an audit on 04/06/23 attached is the order for the medication in question. Wellness Director provided education to the Med Techs regarding locations on order. We recently went to PointClickCare EMR, residents moved in before March on 2023 are still paper charts. Residents after March 2023 are uploaded in PCC.	04/06/2023

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	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 facility failed to ensure a physician order was provided for medications on-site to administer as prescribed for 1 of 10 sampled residents (Resident #9) Resident #9 Resident #9 was admitted to the facility on 11/24/19, with a diagnosis of memory loss. Resident #9's January 2023 Medication Administration Record (MAR) documented Morphine 100/5 milliliters. give 0.25 milliliters (5 milligrams) by mouth every 15 minutes for pain as needed. On 01/24/23 at 2:20 PM, a Medication Technician confirmed the physician order for this medication could not be located and had not been dispensed to the resident since		Monthly audits will be completed by Wellness Director and or Executive Director.	

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	the medication had been received into the facility. The facility policy titled "Medication Policy," last revised November 2012, documented all medications dispensed by the community are to be reordered in sufficient time to ensure residents did not run out of a medication. All medication associates were responsible for keeping track of the need for medication refills, and obtaining proper physician orders for those medications. Severity: 2 Scope: 1			
0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure written instructions indicating the specific symptom(s) for which an as needed (PRN) medication was to be given was documented for 1 of 10 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 01/18/17, with diagnoses including chronic anticoagulation, hypertension and benign prostatic hyperplasia. Resident #2's Medication Administration Record (MAR) dated January 2023, documented hydroxyzine HCL 25 milligram (mg) tablet, take one tablet by mouth four times daily as needed. The hydroxyzine lacked the reason to give the medication. Resident #2's physician order dated 06/17/22, documented hydroxyzine HCL 25 milligram (mg) tablet,	0905	Executive Director and Wellness Director audited resident medications on 04/06/23. Wellness Director will ensure when getting new orders, if it's PRN medication the directions will include the reason why this medication is to be given. Wellness Director and Executive Director will audit the beginning of each month to ensure the reason for PRN will be included on order.	04/06/2023

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	take one tablet by mouth four times daily as needed. The physician order lacked the reason to give the medication. On 01/24/23 at 1:47 PM, the Medication Technician confirmed Resident #2's MAR and physician order for hydroxyzine HCL lacked the specific reason to administer the medication. The Medication Technician verbalized staff would not know why to give the medication and would need to get a clarification from the physician. Severity: 2 Scope: 1			
0938 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on clinical record review, document review, and interview, the facility failed to ensure an Activities of Daily Living (ADL) Assessment was completed on or before admission for 3 of 10 sampled residents (Resident #3, 7, and 9). Findings include: Resident #3 Resident #3 was admitted to the facility on 09/12/22 with a diagnosis of early onset of Alzheimer's disease. Resident #3's initial ADL Assessment was dated 09/19/22. On 01/24/23 at 2:05 PM, the Executive Director confirmed Resident #3's initial ADL	0938	Executive Director and Director of Business' development audited ADL Record book 04/05/23. 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.	04/05/2023

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	assessment was completed late. Resident #7 Resident #7 was admitted to the facility on 06/02/22, with diagnosis of unspecified dementia with behavioral disturbance. Resident #7's initial ADL Assessment was dated 07/07/22, and was not completed on or before date of admission. On 01/24/23 at 10:55 AM, the Front Desk Concierge verbalized being responsible for ensuring completed initial documentation for all residents and confirmed Resident #7 initial ADL assessment was not completed on or before date of admission. On 01/24/23 at 2:15 PM, the Executive Director confirmed Resident #7's ADL initial assessment was not valid and verbalized ADL assessments were to be completed upon admission for all residents, to include the date completed and signature of staff completing the assessment to determine validity of the assessment. Resident #9 Resident #9 was admitted to the facility on 11/24/19, with a diagnosis of memory loss. Resident #9's initial ADL Assessment was dated 01/06/2020, and was not completed on or before date of admission. On 01/24/23 at 10:55 AM, the Front Desk Concierge verbalized being responsible for ensuring completed initial documentation for all residents and confirmed Resident #7 initial ADL assessment was not completed on or before date of admission. On 01/24/23 at 2:15 PM, the Executive Director confirmed Resident #9's ADL initial assessment was not valid and verbalized ADL assessment's were to be completed upon admission for all residents, to include the date completed and signature of staff completing the assessment to determine validity of the assessment. Severity: 2 Scope: 2			

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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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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 printed from website and hung in common areas at the end of day on 01/24/23. Executive Director will add to daily walk through list to ensure all is posted in required areas	01/24/2023

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1540 SS= E	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 personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 2 of 9 sampled employees required to obtain cultural competency training (Employees #2 and #6). Findings include: On 01/24/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. The Corporate Executive Director provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Executive Director with a start date of 04/07/22. The personnel record for Employee #2 lacked a cultural competency training certificate, 207 days after the required 30 days. Employee #6 Employee #6 was hired by the facility as Executive Director with a start date of 09/28/22. The personnel record for Employee #6 contained a cultural competency training certificate dated 11/15/22, 18 days after the required 30 days. Severity: 2 Scope: 2	1540	Executive Director and Business' office Manager audited Employee files on 03/30/23. All files are in compliance. Executive Director and Business office manager will auditing employee files the end of every month.	03/30/2023