DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**02/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	**5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 02/02/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The census at the time of the survey was 94. The sample size was five. Two complaints were investigated. Complaint #NV00062147 with the following allegations could not be substantiated. Allegation #1 a resident experienced weight loss as a result of the facility not honoring the resident's food preferences and not assisting the resident with meals could not be substantiated based on interviews, observations and record review. The investigation into the allegation included: Interviews were conducted with the resident of concern, the Executive Director (ED), the Health and Wellness Director, a Care Partner/Medication Aide and a Dining Services Partner The resident of concern verbalized the resident received enough to eat and staff offered substitutes if the resident did not want the meal provided. The resident verbalized staff helped the resident with opening containers and provided assistance as needed when eating. A Dining Services Partner verbalized the menu for the week was posted in common areas within the facility and copies of the menus were also provided to residents. Observations of the resident of concern, menu postings throughout the facility, and availability of snacks, substitutes and preferred foods. Review of the resident of concerns record for recorded weights, care plans, and diet orders. The resident had maintained a steady weight throughout January 2021. The resident's care plan documented the resident required assistance with setting up at mealtimes and resident food preferences were documented. Review of the facility policy for Dining Assistance. The policy documented	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	staff would review the Resident's Service Plan to determine the type of assistance required by the resident. Alternatives were available at every meal. Allegation #2 a resident's family was not notified of a resident's change in condition or when the facility called an ambulance was not substantiated based on interview and document review. The investigation into the allegation included: Interviews were conducted with the resident of concern, the ED, and the Health and Wellness Director. The ED and Health and Wellness Director verbalized phone calls from the facility would go unanswered when contacting the family and the Health and Wellness Director had texted the information to the family members cell phone after multiple phone call attempts with no answer. Review of the facility policy for health monitoring and intervention. Allegation #3 a resident's room was not cleaned, and staff did not change a resident's sheets was not substantiated based on observation, interview, and document review. The investigation into the allegation included: Observation of the resident of concern's room. The resident's room was free of clutter and odors, surfaces and floor were clean, and the bed was made with clean appearing sheets and blankets. Interviews were conducted with the resident of concern, a Housekeeper, a Care Partner/Medication Aide, and the ED. The resident of concern verbalized the housekeeping staff would clean the resident's room every Tuesday and this included vacuuming the floors and changing the resident's sheets. A Housekeeper verbalized the resident's room was scheduled to be cleaned every Tuesday and the Housekeeper would clean as needed when the resident or staff requested additional cleaning. A Care Partner/Medication Aide verbalized the Care Partner would pick up anything from the resident's floor when the Care Partner was in the resident's room. Review of the Housekeeping Schedule and the facility			

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	policy for resident apartment cleaning. The facility policy documented housekeeping services were typically provided on a weekly basis to residents. The standard service included weekly cleaning of bathroom, weekly change of linens/making of bed, weekly clean-up of the living and bedroom areas, including vacuuming, dusting, emptying trash, picking up and putting away belongings, and weekly cleaning of kitchenette. Allegation #4 the facility did not make sure the resident was taking the resident's prescribed medications was not substantiated based on interview, record review, and document review. Investigation into the allegation included: Interviews were conducted with the resident of concern, a Care Partner/Medication Aide, the Wellness Director, and the ED. The Wellness Director and the ED verbalized the resident had been managing the resident's own medications until 01/22/21 when the facility began managing the resident's medications. The resident verbalized the facility provided the resident with all of the resident's medications and the resident was receiving all medications as prescribed. Review of the Medication Management Authorization documented the resident was self-managing the resident's medications until a new document was completed on 01/22/21 and the resident authorized the facility to possess, administer, and monitor medications. Review of the Medication Administration Record since 01/22/21 documented the resident had been administered all medications as prescribed. Allegation #5 a resident's family was not allowed to visit or check on the resident was not substantiated based on interview and observation. Investigation into the allegation included: Interviews were conducted with the resident of concern and the ED. The resident verbalized the resident spoke to the resident's family via phone daily and had been able to visit with family in the designated visitation area of the facility.			

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	Observation of the visitation area for residents and family. Complaint #NV00063015 with the following allegations could not be substantiated. Allegation #1 the facility was not getting residents vaccinated for COVID-19 (COVID) in a timely manner was not substantiated based on interview and document review. Investigation into the allegation included: An interview was conducted with the ED. The ED verbalized the facility had used a pharmacy to obtain the necessary vaccines. The facility had requested for the vaccine clinic to occur as soon as possible during the initial request on 12/03/20. Review of email communication regarding the vaccine clinic, beginning 12/03/20 documented frequent requests and attempts to get the clinics set up as soon as possible. The pharmacy was unable to allocate the requested number of vaccines until the date of the first clinic on 02/03/21. Allegation #2 the facility did not inform resident family members of COVID-19 positive cases in the facility was not substantiated based on interview and document review. Investigation into the allegation included: An interview was conducted with the ED. The ED verbalized the ED had sent emails to resident family members to notify them when a resident tested positive for COVID in the facility. Review of an email sent to family members after a resident tested positive on 12/17/20. The email included potential exposure and transmission within the facility, steps facility was taking to increase the monitoring of other residents and steps the facility would take when a resident tested positive. Allegation #3 the facility was not accommodating visitation between residents and resident's family members was not substantiated based on interview, observation, and document review. Investigation into the allegation included interviews with residents, the concierge, and the ED. A resident verbalized the resident had visited with family in the designated visitation area and			

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	the facility assisted with arranging the visit. The Concierge verbalized the concierge would use bleach wipes to clean the visitation area after every visit. The ED verbalized the facility had assisted with window visits and then transitioned to using a designated visitation area to provide more privacy and comfort during visits. Observation of the visitation area. The area consisted of a Plexiglas partition in a doorway, two chairs were placed on one side of the Plexiglas for visitors and a table and chair were on the other side of the Plexiglas for the resident. Review of the facility policy for visitation and procedure during the COVID-19 pandemic documented the facility would identify measures to provide residents with safe methods to interact with families and friends. Allegation #4 the facility posted a picture of a resident on social media and the resident was not wearing a facial covering was not substantiated based on interview and observation. Investigation into the allegation included: An interview was conducted with the ED. The ED verbalized the picture posted to social media was of a memory care resident on the resident's birthday. All staff in the picture were wearing a mask and the resident did not wear a mask due to difficulty in keeping the mask on the resident as a result of the resident's dementia diagnosis. Observation of residents throughout the assisted living facility wearing facial coverings. Nine residents were observed in the activity room social distancing and all wore facial coverings. Residents in memory care were kept distanced from other residents and all staff were wearing masks. The facility received a grade of A. 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. No regulatory deficiencies			

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	were identified.			