

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Reno		STREET ADDRESS, CITY, STATE, ZIP CODE 961 Kuenzli Street Reno, NV 89502	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30748</p> <p>Based on observation, interview, and document review, the facility failed to ensure medications were not left unattended and unsecured in the dining room during a medication pass, creating a potential accident when a licensed nurse left the medications at a resident's table and walked away, resulting in the medications out of the nurse's line of sight for supervision for 12 of 12 residents in the dining room.</p> <p>Findings include:</p> <p>On 10/28/2024 at 12:08 PM, there were three residents seated at a table together awaiting lunch meal service. A Licensed Practical Nurse (LPN) set a small cup containing a white pill inside of the cup on the residents' table. The LPN turned around and walked away from the table to retrieve a cup of water, leaving the unknown pill unsecured and unsecured at the dining table. The LPN returned to the residents' table with the cup of water and the resident administered the medication.</p> <p>On 10/28/2024 at 12:12 PM, the LPN confirmed leaving the pill unsecured and unsupervised at the three residents' table, while nine other residents were also in the dining room. The LPN verbalized it was not best practice for a nurse to leave a pill unsecured and unsecured during medication administration to any resident and explained other residents could have taken the pill and had a reaction to the pill. The LPN verbalized the white pill was hydrocodone and was a controlled substance.</p> <p>On 10/30/2024 at 2:06 PM, the Director of Nursing (DON) explained nurses were to observe residents taking medications and were not to leave the resident while administering medications to the resident. The DON verbalized leaving a controlled substance unsecured and unsupervised was a concern and nurses were to keep the medication within line of sight to avoid another resident ingesting the medication, putting the medication in their cheeks, socks or pants pockets to ingest at a later time.</p> <p>On 10/30/2024 at 2:10 PM, the Administrator explained while nurses were administering medications, the nurse was to stay with the resident and keep eyes on the medications at all times until the medication was ingested.</p> <p>The facility policy titled Administration of Medication, undated, documented a licensed nurse was to stay with the resident until all medications had been ingested and medications were to be locked in the medication cart whenever the medication was out of view.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>40377</p> <p>Based on personnel record review, document review and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) had an annual performance evaluation completed timely and identified and addressed areas of weakness for 3 of 3 sampled CNAs employed greater than one year, selected for personnel record review (Employee #21, #22, and #23).</p> <p>Findings include:</p> <p>Employee #21</p> <p>Employee #21 was hired by the facility as a CNA with a start date of 01/16/2023.</p> <p>Employee #21's personnel record documented the following:</p> <ul style="list-style-type: none"> - a facility Employee Performance Review dated 02/14/2024, one month late. - a facility Competency Checklist dated 01/25/2024, nine days late. The Competency Checklist lacked documented evidence of Employee #21's performance strengths or weaknesses. - a facility Follow-up Evaluation dated 02/12/2024, documented the areas of concern, including duties for trash, water, bed made and room clean prior to giving report. <p>Employee #22</p> <p>Employee #22 was hired by the facility as a CNA with a start date of 09/09/2021.</p> <p>Employee #22's personnel record documented the following:</p> <ul style="list-style-type: none"> - a facility Employee Performance Review dated 09/19/2024, ten days late. - a facility Competency Checklist dated 01/25/2024. The Competency Checklist lacked documented evidence of Employee #22's performance strengths or weaknesses. - a facility Follow-up Evaluation dated 10/10/2024, documented the areas of concern, including improving donning and doffing process. <p>Employee #23</p> <p>Employee #23 was hired by the facility as a CNA with a start date of 06/30/2023.</p> <p>Employee #23's personnel record documented the following:</p> <ul style="list-style-type: none"> - a facility Employee Performance Review dated 09/03/2024, over two months late. <p>(continued on next page)</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- a facility Competency Checklist dated 01/25/2024. The Competency Checklist lacked documented evidence of Employee #23's performance strengths or weaknesses.</p> <p>- a facility Follow-up Evaluation dated 10/09/2024, documented the areas of concern, including improving employee's therapeutic communication with residents to be encouraging and educational.</p> <p>On 10/31/2024 at 11:38 AM, the DON confirmed the facility's Performance Evaluation Form did not evaluate the CNAs' skills and identify the employee's strengths and weaknesses. The DON verbalized the DON conducted a skills competency fair at the facility for CNAs in January 2024. The DON verbalized the facility's Competency Checklist did not identify the employee's strengths and weaknesses and provide the ability for the facility to identify the training needs to address any of the employee's weaknesses.</p> <p>The facility policy titled CNA Staff Evaluation, updated December 21, 2023, documented the Administrator and/or employee's supervisor would complete a performance evaluation annually on each Certified Nursing Assistant (CNA). During the evaluation the evaluator and employee will identify an areas that need improvement.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>43311</p> <p>Based on observation, interview, and document review, the facility failed to ensure a medication cart and medications left on top of a medication cart were secured for 1 of 3 medication carts.</p> <p>Findings include:</p> <p>On 10/31/2024 at 7:10 AM, the top left drawer of a medication cart was left ajar and unlocked and three Lidocaine 5 percent (%) transdermal patches were on top of the cart and unsecured. A nurse was not at or near the cart and no other staff was present in the hallway.</p> <p>On 10/31/2024 at 7:14 AM, a Licensed Practical Nurse (LPN) returned to the medication cart and confirmed the top drawer was left ajar and unlocked, and three Lidocaine 5% transdermal patches were left on top of the medication cart. The LPN explained the LPN was administering medications to a resident and had left the Lidocaine patches on top of the cart and left the cart unsecured. The LPN verbalized the medication could have been taken and ingested by anyone in the hallway, including other residents, and could have resulted in an adverse reaction, overdose, or death.</p> <p>On 10/31/2024 at 7:48 AM, the Director of Nursing (DON) explained the expectation of nursing staff was to maintain sight of the medication cart at all times or to lock the cart when not present. The DON verbalized the Lidocaine patches could have been taken, used, and/or ingested by someone who did not have an order to take the medication and should have been secured in the medication cart.</p> <p>The facility policy titled Medication Storage, updated 09/28/2022, documented medications were stored safely, securely, and properly. The medication supply was accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication carts were locked or attended by persons with authorized access.</p>		