Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10513	A. BUILDING _____ B. WING _____	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR SERENITY	465 SYSONBY CT, RENO, NEVADA ,89521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 09/13/2024. 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 is licensed for six Residential Facility for Group beds for elderly and disabled persons, one Category I resident and five Category II residents. The census at the time of the survey was five. Five resident records and five employee records were reviewed. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ALAN BARCELON | Title: Administrator | Date: 10/07/2024

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0251 SS= F	Storage of Food-Perishable Foods Refrigerated - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. Inspector Comments: Based on observation and interview, the facility failed to ensure five dozen, raw eggs, were stored in the refrigerator. This deficient practice had the potential to affect five of five residents. Findings include: On 09/13/2024 at 9:33 AM, located in a kitchen cabinet was a box of Kirkland raw eggs. The box had five dozen eggs. On 09/13/2024 at 9:33 AM, the Caregiver confirmed there was a box of five dozen raw eggs, located in a kitchen cabinet. The Caregiver acknowledged the box documented the eggs were to be kept in the refrigerator. The Caregiver opened the sealed box to feel the temperature of the eggs and confirmed the eggs were at room temperature. On 09/13/2024 at 9:43 AM, the Manager explained eggs were not to be stored anywhere in the facility except for the refrigerator. If residents were served the eggs, sitting out for an undetermined amount of time, the residents could get a serious illness. Severity: 2 Scope: 3	0251	1.) The eggs were thrown to the garbage the same day. 2.) The caregivers are asked to asked to inform manager if they are bringing food to rhe facility. Then inform manager of what food will be brought in. 3.) The administartor and manager will check and monitor the pantry to make sure refrigerated items needs to be in the refrigerator. 4.) Administrator and manager. 5.) 9/13/2024 6.) Since this deficiency was caused by mental error by the caregivers, the are no documents to be attached. Reminders to the caregivers will be implemented.	09/13/2024
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container	0920	1.) The caregivers were asked not to use medication cup to pre fill medication ahead of time. 2.) The caregivers were reprimanded and informed that this practice is not acceptable. Another incident observed by the administrator and manager will be grounds for immediate termination. 3.) The administrator and manager will routinely and randomly check the drawers and cabinets to make sure the deficient practice will not happen.We will also remind caregivers about the possibility of employment termination. 4.) Administrator and manager. 5.) 9/13/2024. Caregivers were reprimanded that same day. 6.) No documentation since only verbal reprimands was done.	09/13/2024

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	for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were stored securely for 5 of 5 residents (Resident #1, #2, #3, #4, and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/12/2023, with diagnoses including cognitive decline, gastroesophageal reflux disease, and osteoporosis. Resident #2 Resident #2 was admitted to the facility on 04/17/2024. Resident #3 Resident #3 was admitted to the facility on 03/18/2023, with diagnoses including edema, chronic obstructive pulmonary disease, and cardiovascular accident after coronary artery bypass graft. Resident #4 Resident #4 was admitted to the facility on 08/31/2023, with diagnoses including vascular dementia without behavioral disturbance, cerebral atrophy and hyperlipidemia. Resident #5 Resident #5 was admitted to the facility on 06/03/2023, with diagnoses including hypothyroidism, hypertension and psychosis. On 09/13/2024 at 9:33 AM, located inside of a kitchen drawer were two cups of medications for Resident #1 and Resident #5. A second kitchen drawer contained pre-poured afternoon medications for Resident #1, #2, #3, #4 and #5. On 09/13/2024 at 9:39 AM, the Caregiver confirmed all resident medications were left unsecured and explained the Caregiver always pre-poured resident medications for the day, placed them in a kitchen drawer and administered to the residents during meal times. On 09/13/2024 at 9:43 AM, the Manager explained resident medications were to be locked at all times and resident medications were being pre-poured to save the Caregiver time throughout each day. The Manager verbalized the pre-poured medications needed to be locked at all times to prevent residents from finding medications not belonging to them and administering the medications to			

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	themselves. The Manager explained all resident medications were left unsecured and had the potential to negatively impact each residents health if the residents were to ingest medications not belonging to the resident. Severity: 2 Scope: 3			