

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 6389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2020
NAME OF PROVIDER OR SUPPLIER GOLDEN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SYSONBY CT, RENO, NEVADA ,89521		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed in your facility on 08/25/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Groups beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. Six resident files and five employee files 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:			

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

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(X4) ID PREFIX TAG 0885 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to remove and destroy medications in a timely manner for a resident who passed away. Findings include: On 08/25/20 at 12:12 PM, located in the laundry room storage cabinet was the following medication: -Nystatin Topical Powder. Apply to groin folds four times daily until clear, prescribed to a resident whom passed in July 2020. On 08/25/20 at 12:12 PM, the Caregiver verbalized the resident had passed away in July 2020 and the medication should have been destroyed upon the date of death. The Caregiver confirmed the medication was not destroyed and could not recall why the medication was put in the laundry room storage area. On 08/25/20 at 1:11 PM, the Owner explained the resident had passed away July 2020 and all medications related to the resident should have been destroyed upon the date of the resident's passing. Severity: 2 Scope: 1	ID PREFIX TAG 0885	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. The deficiency can be corrected by making sure that medication destruction process is followed and recorded in every Resident's medication file, from securing orders, to properly documenting the destruction process, and finally keeping and maintaining all records for each resident. 2. Deficiencies like this are managed by following timely medication destruction procedure and collection and recording of information on the Medication Administration Record. 3. Future deficiencies like this can be avoided by timely destruction of medications that has been discontinued or not needed anymore due to death or transfers of the Resident. 4. The manager/administrator will be responsible in monitoring medication management. 5. The deficiency was corrected on Aug 25, 2020.	(X5) COMPLETION DATE 08/25/2020
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.	0920	1. On the day of the inspection the manager held a meeting reinforcing the need for medications to be in a secure and safe place. The employees were reminded that all medications need to stay in the locked cabinets at all times and only taken out when its time for the Medications to be given. 2. Deficiencies like this can be managed by making sure that staff are educated on the importance of keeping medications	08/25/2020

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	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 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 in a locked area for 2 of 6 residents (Resident #3 and #4), one unsampled resident (unsampled Resident #1). Findings include: Resident #3 Resident #3 was admitted to the facility on 04/02/19, with diagnoses including hypertension, mental illness and glaucoma. Resident #4 Resident #4 was admitted to the facility on 01/27/20, with diagnoses including dementia, history of falls and benign essential hypertension. Unsampled Resident #1 Unsampled Resident #1 was admitted to the facility on 08/01/19 and passed away on 07/20/20. On 08/25/20 at 12:00 PM, during a tour of the facility, the following medications were found in an unlocked kitchen drawer: -Eight medication administration cups with unknown prescription pills -Two bottles of Latanoprost 0.005% eye drops. Give one drop in both eyes every evening, prescribed for Resident #3. -Two bottles of eye drops with no resident name. -Acetaminophen 650 milligram (mg). Take two tablets by mouth every six hours as needed for pain, prescribed to Resident #3. -Two boxes of refresh tears with a post it note documenting for Resident #4. On 08/25/20 at 12:05 PM, the Caregiver confirmed the medications were unsecured and verbalized if a resident were to swallow the pills not prescribed to them, it could negatively effect their health. On 08/25/20 at 12:12 PM, located in the laundry room storage cabinet was the following medication: -Nystatin Topical Powder. Apply to groin folds four times daily until clear, prescribed to a		secured. 3. Future deficiencies like this can be avoided by regular medication management meeting and by checking by the managers that protocols/policies on Medication management, specifically storage and safety are followed. 4. The staff-in-charge will be responsible in making sure that all medications are secured, and the manager/administrator are responsible in the regular medication management meetings and checking that policies are followed. 5. The deficiency was corrected on August 25, 2020.	

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	resident whom passed in July 2020. On 08/25/20 at 12:15 PM, the Caregiver confirmed the medication was unsecured in the laundry room and verbalized the medication belonged to a resident who had passed away recently. The Caregiver could not recall why the medication was located in the laundry room and verbalized the medication should have been destroyed upon the date of the residents passing. On 08/25/20 at 1:11 PM, the Owner verbalized all medications were to be locked at all times unless actively being administered to residents. Severity: 2 Scope: 3			