STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11051	A. BUILDING _____ B. WING _____	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WRIGHT GROUP HOME OF LOVELOCK	685 AMHERST AVE, LOVELOCK, NEVADA ,89419

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a regrading State Licensure survey and Complaint investigation conducted at your facility on 06/20/2024. 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 was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or mental illness and/or Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Seven resident files and five employee files were reviewed. The facility received a grade of D. There was one complaint investigated. Complaint #NV00071931 with an allegation a resident had eloped from the facility and was located deceased was substantiated (See Tag #0050). A deficiency unrelated to the allegation was identified (see Tag 1037). 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, action 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		
0050 SS= J	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview and clinical record review, the facility failed to provide protective supervision for a resident who eloped from the facility, resulting in the death of the resident (Resident #8). Findings include: On 06/20/2024 at 9:28 AM, upon entry to the facility, there was a closed patio with a	0050	Based on the findings of resident #8 resulting in his death, it had been my instruction to the caregivers to always do a head count on the residents at all times. Although a 24 hour supervision is in place, caregivers lost sight of his exit but until now we could not figure out how he eloped from the facility when the caregiver opened the locked door to let the resident who smokes out and let him in after smoking. Resident #8 had lived in the facility for almost two (2) years, closely watched and supervised due to his history of elopement. Since there are two (2) caregivers, one awake as required by the State for category II facilities we will insure that this deficient practice will not occur again. Caregivers will be aimed to attend a face to face training if available to better educate them and understand the nature of work	07/09/2024

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	metal screen door. The metal screen door was locked and required a staff member open the door to permit entry into the facility. When entering the enclosed patio area, located on the metal screen door was a doorknob with a standard twist motion lock and a deadbolt lock. During the tour of the facility, there were two doors leading outside of the facility. Each door had an automatic locking mechanism when the door would close, preventing residents from eloping from the facility, and a keypad requiring a code to be entered for the door to unlock. On 06/20/2024 at 9:48 AM, the Owner verbalized there was a minimum of two Caregivers present in the facility at all times because the facility was required to meet a ratio of one caregiver per every 5 or 6 residents. The purpose of the ratios was to keep all residents safe and provide proper supervision to each resident. Resident #8 Resident #8 was admitted to the facility on 08/16/2022, with diagnoses including dementia, atrial fibrillation, and encephalopathy. A History and Physical dated 07/01/2022, documented Resident #8 has severe cognitive impairments and decline as a result of dementia. The Standard Placement Determination dated 08/05/2022, documented Resident #8 was permitted to be placed in a residential facility which provide care to persons who were elderly or disabled or who required assistance or protective supervision because the resident possibly suffered from infirmities or disabilities. Incident Reports with dates ranging from 10/03/2022 to 05/05/2023, documented the resident had attempted to elope from the facility eight times. An incident report dated 05/10/2024, documented Resident #8 was observed going to the resident's room, however, did not come out of the room for snack. The Caregiver prepared the resident's snack and went to the resident's room to provide the snack. The resident was not observed in the room. The Caregiver proceeded to check the restrooms and facility for the resident and could not locate the resident. The Caregiver placed a call to emergency dispatch to report the resident missing. An incident report dated 05/12/2024, documented on 05/12/2024 at 4:00 AM,		they are in. Our improvements are as follows; Installing new fiberglass door at 9:00 tomorrow and 10:00 technician from ABC now know as Summit Fire Protection will come and install magnetic door lock on new door. We are looking for company who can install security cameras outside for further security of the facility.	

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	Resident #8 had been located miles away from the facility, deceased. A staffing schedule dated May 2024, documented on May 10, 2024, there were two Caregivers present in the facility. On 06/21/2024 at 10:26 AM, the Caregiver explained Resident #8 attempted to elope from the facility almost on a daily basis and had a history of wandering. The Caregiver verbalized on 05/10/2024, Resident #8 has wandered to their room. During the scheduled evening snack time, the resident was not at the dining room table like the resident had done every day. The Caregiver prepared a snack for Resident #8 and took the snack to the resident's room. The Caregiver could not locate the resident in their room and proceeded to check the restrooms for the resident. The Caregiver then checked the rest of the facility for the resident and failed to locate the resident. As a result, the Caregiver called emergency dispatch to file a missing resident report. Emergency personnel initiated a search for Resident #8 and continued to search for the resident for two days before locating the resident who was deceased. The Caregiver verbalized not knowing how the resident eloped from the facility because all the doors leading outside had a keypad lock requiring a code to exit the facility. The Caregiver confirmed Resident #8 eloped from the facility, resulting in the resident's death. On 06/21/2024 at 10:31 AM, the Owner explained on 05/10/2024 at 9:00 PM, the Caregiver on shift for the evening had called the Owner to inform the Owner Resident #8 had eloped from the facility and was missing. The Owner verbalized the resident had been missing for two days before being discovered deceased, on private property nearly a mile away from the facility. The Owner explained there was one resident in the facility who was an active cigarette smoker and would go out on the front porch daily to smoke. During the resident's smoke breaks on the front porch, the front door to the facility would remain unlocked until the resident was able to finish a cigarette. On 05/10/2024, the resident was outside smoking a cigarette when Resident #8, walked out of the front door of the facility and through the gate on			

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	the porch leading to the street. The Owner confirmed no supervision was provided to the resident smoking because that resident did not have a diagnosis of dementia or Alzheimer's and as a result of the lack of supervision, Resident #8 was able to elope from the facility. The Owner verbalized there were two Caregivers on shift at the time Resident #8 had eloped from the facility, and the resident attempted to elope quite often from the facility. The Owner confirmed the facility failed to supervise Resident #8, who had tried to elope just about every day since the day of admission, resulting in Resident #8 eloping from the facility and passing away. The Owner confirmed the health and safety of every resident in the facility was in jeopardy because of the unlocked door and was required to keep the facility entrances and exits secure at all times. Severity: 4 Scope: 1			
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 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	0074	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024

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	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, 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			

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	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.			
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive.	0104	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.	0178	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024

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0430 SS= D	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire.	0430	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024
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.	0451	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024
0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care.	0859	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024

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0885 SS= D	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.	0885	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication.	0895	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered.	0923	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024
0938 SS= D	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.	0938	Please refer to original Statement of Deficiency/Plan of Correction - Event ID JK2111.	04/05/2024
1037 SS= F	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an	1037	Based on your findings all employees need to have three (3) hours of training providing care to a resident with dementia. Please see attachments with certificates of all employees, administrator and owner. Administrator will monitor that training will be done based on State guidelines. Administrator will make sure that it never happens again.	07/09/2024

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	occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the Administrator failed to ensure 3 of 5 sampled employees completed the required minimum of additional three hours of training in providing care to a resident with dementia by the hire anniversary date (Employee #1, #2 and #5). Findings include: Employee #1 Employee #1 was hired at the facility as the Administrator with a start date of 09/26/2022. Employee #1's personnel file lacked documented evidence of three hours of annual dementia training. Employee #2 Employee #2 was hired as the Owner with a start date of 01/03/2022. Employee #2's personnel file documented one hour of annual dementia training completed. Employee #2's lacked the required three hours of dementia training by the employee's anniversary date. Employee #5 Employee #5 was hired as a Caregiver with a start date of 01/03/2022. Employee #5's personnel file documented one hour of annual dementia training completed. Employee #5's lacked the required three hours of dementia training by the employee's anniversary date. On 06/20/2024 at 11:26 AM, the Owner and			

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	Caregiver confirmed employee's #1, #2, and #5 lacked the required three hours of annual dementia training. Severity: 2 Scope: 3			