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 _____	**09/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 10/23/20 and completed on 09/24/21. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The census at the time of investigation was 28. The sample size was seven. There were thirteen complaints investigated. Complaint #NV00061900 with the following allegations could not be substantiated. Allegation #1: Staff were hanging out in a resident room, leaving residents unsupervised could not be substantiated because interviews with staff and residents could not prove staff were hanging out in rooms. Allegation #2: Staff were high on drugs while on shift could not be substantiated because there was a lack of evidence to support the allegation. Allegation #3: Staff were smoking marijuana in the facility could not be substantiated because interviews conducted with staff and residents did not support the allegation. Allegation #4: There was an odor of marijuana in the hallways of the facility could not be substantiated because there were no odors indicative of marijuana. Allegation #5: Staff were sleeping while on duty leaving residents unsupervised was not substantiated because there was no proof to support the allegation. Allegation #6: Residents were not receiving their medications could not be substantiated because all residents verbalized receiving medications appropriately. The investigation into the allegations included: Observation of staff and resident interactions, unsecured medications, drugs on the premises of the facility, resident rooms, and resident medication administration. Interviews were conducted with the Assistant Manager, a Medication Technician, a Housekeeper and eight residents. A review of seven resident files including the resident of concern.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AFRODESIA LOPOZ Title: Administrator Date: 04/01/2022

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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	Document review included staffing schedules, incident reports and documents to support written reprimands against employees. Complaint #NV00062222 with the following allegation could not be substantiated. Allegation #1: Call lights were ignored could not be substantiated because residents verbalized being helped within a matter of minutes after pressing the call light. The investigation into the allegations included: Observation of staff and resident interactions, call lights functioning, and resident safety. Interviews were conducted with the Assistant Manager, a Medication Technician, a Housekeeper and eight residents. A review of seven resident files including the resident of concern. Document review included staffing schedules and incident reports. Complaint #NV00061991 with the following allegations could not be substantiated. Allegation #1: Resident had been naked in bed with staff not tending to the resident's needs could not be substantiated because interviews and observations did not support the allegation. Allegation #2: Resident left naked, and brief soaked in urine during the night could not be substantiated because of lack of evidence to support the allegation. The investigation into the allegations included: Observation of staff and resident interactions, resident rooms, stockpile of briefs for each resident and call lights functioning and within reach of residents. Interviews were conducted with the Assistant Manager, a Medication Technician, a Housekeeper and eight residents. A review of seven resident files including the resident of concern. Document review included staffing schedules and incident reports. Complaint #NV00061992 with the following allegations could not be substantiated. Allegation #1: Resident was left naked and exposed could not be substantiated because of lack of evidence to support the allegation. Allegation #2: Resident's privacy was not protected could not be substantiated because there was no			

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	evidence to support privacy of resident's not being protected. The investigation into the allegations included: Observation of staff and resident interactions, resident rooms, stockpile of briefs for each resident and call lights functioning and within reach of residents. Interviews were conducted with the Assistant Manager, a Medication Technician, a Housekeeper and eight residents. A review of seven resident files including the resident of concern. Document review included staffing schedules and incident reports. Complaint #NV00061359 with the following allegations was substantiated (See Tags Y0102 and Y0450). Allegation #1: Caregiver did not have a Tuberculosis (TB) test completed prior to working with residents (See Tag Y0102). Allegation #2: Caregiver did not have a CPR & First Aid card prior to working with residents (See Tag Y0450). The following allegations could not be substantiated. Allegation #3: Caregiver did not have a physical exam prior to working with residents could not be substantiated because the employee had not started working on the floor with residents through the current date. Allegation #4: Staff working in the kitchen did not have proper training could not be substantiated because all kitchen staff had the required training to handle food in the kitchen. Allegation #5: Staff working without a valid green card could not be substantiated because all legal documents were present in the employee files and available for review. Allegation #6: An employee was bringing their infant to work during their shift exposing the baby and residents to germs during a pandemic could not be substantiated because interview, observation and document review lacked evidence to support the allegation. The investigation into the allegations included: Observation of staff and resident interactions, kitchen staff handing of food, and any individuals that may have been present in the facility during a pandemic. Interviews were conducted with the			

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	Assistant Manager, a Medication Technician, a Cook, a Housekeeper and eight residents. A review of eleven staff files was completed. Document review included staffing schedules, training provided to staff, current CPR and First Aid training, physical exams, TB tests completed for staff, government issued clearances and identification of each employee, Elder Abuse training, Employment Eligibility Verification forms, completed background checks for employees and work card clearances for staff. Complaint #NV00064847 with the following allegations was substantiated. Allegation #1: No employees on site (See Tags Y0050, and Y0085). Allegation #2: Residents not receiving showers (See Tags Y0590). Allegation #3: Residents not assisted out of bed or assisted with transfers (See Tags Y0590). Allegation #4: Facility was short staffed, as a result, sick staff were coming in to work (See Tags Y0050 and Y0085). Complaint #NV00061731 with the following allegations could not be substantiated. Allegation #1: Employee to employee abuse could not be substantiated because interviews conducted with staff and residents did not support the allegation. Allegation #2 Employee bringing a child to the facility during working days could not be substantiated because there was no child in the facility and interviews conducted with staff and residents did not support the allegation. Allegation #3 A Caregiver slapped a resident in the head could not be substantiated because an interview with a resident who supposedly witnessed the allegation denied the allegation happened. The investigation into the allegations included: Observation of staff and resident interactions. Interviews were conducted with the eight residents and the Assistant Manager. A review of seven resident files and facility reported incidents. Complaint #NV00061890 with the following allegations could not be substantiated. Allegation #1: Cook not trained in food handler training			

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	could not be substantiated because the two cooks on staff had certificates for food handler training. Allegation #2: Cook not wearing a hairnet or gloves could not be substantiated because kitchen staff were wearing hairnets, gloves, and masks. The investigation into the allegations included: Observations of kitchen staff. Interviews were conducted with the weekday Cook, the weekend Cook/Assistant Manager. A review of both Cook's personnel files. Complaint #NV00061899 with the following allegations could not be substantiated. Allegation #1: A resident eloped from the facility on 08/25/20 could not be substantiated because there was a lack of evidence to support the allegation. Allegation #2: Two staff members are sleeping during working time could not be substantiated because interviews with staff and residents did not support the allegation. The investigation into the allegations included: Observations of facility staff. Interviews with a Housekeeper, Medication Technician and Assistant Manager. Interviews with eight residents. Complaint #NV00061920 with the following allegation could not be substantiated. Allegation #1: A Certified Nursing Assistant came upon a resident left wet for an extended period could not be substantiated because observation of residents and interviews with eight residents did not support the allegation. The investigation into the allegation included observation and a tour of the residents' rooms, and interviews conducted with eight residents. Complaint #NV00062012 with the following allegation could not be substantiated. Allegation #1: A resident's room smelled, bedding left soaked and not changed could not be substantiated because none of the residents' rooms smell during the tour of the facility and observations of residents bedding was clean and dry. The investigation into the allegation included observation and a tour of the residents' rooms, and interviews conducted with eight residents. Complaint			

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	#NV000061993 and #NV000062161 with the allegation the facility had bed bugs was substantiated (See Tag Y0174). 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:			
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 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 resident medications were kept secured in the facility. Findings include: On 09/24/21 at 8:15 AM, the door to the medication room, was open. All resident medications were kept in the medication room. In addition, upon entering the medication room it was discovered the medication cart was unlocked and could be opened. On 09/24/21 at 8:28 AM, a Caregiver walked	0920	1. The Med Tech were reminded or their duty to comply. Attached memo circulated among Med Techs. 2. We are making this change: a) the med room must be always close even when the med tech is in the med room (this is a change to practice where med techs leave the door open when they are inside the med room b) the med tech must visibly be hanging the key to the med room around her/his neck to remind of the duty to lock the door when not inside c) the supervisor will check 2 things - visible closed door and check if the door is locked or if the med tech is in the room. d) never leave the door open and keep it locked when leaving the med room. 3. Daily the supervisor will randomly check the practice and discuss compliance in the daily turnover of med techs. 4. Supervisor - and the Administrator will check compliance. 5. implementation started today with a meeting and a memo.	03/21/2022

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	into the medication room from the back of the facility. The Caregiver confirmed all resident medications were unsecured because the door to the medication room was left open. The Caregiver confirmed the medication cart was unlocked and accessible to all residents. The Caregiver verbalized all medications were to be locked when a caregivers were not in the room because residents can get into the medications. On 09/24/21 at 8:50 AM, the Owner verbalized all medications were to be locked at all times to prevent residents being able to take other resident medications. The Owner explained the expectation for staff was to always lock the medication room when not in the medication room and medications were to be secured at all times to avoid residents having access to the medications. Severity: 2 Scope: 3			
0050 SS= F	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 document review, the Administrator failed to provide oversight and supervision to residents to ensure the facility complied with certain requirements of Nevada Administrative Code 449.156 to 449.27706, inclusive, and Nevada Revised Statutes Chapter 449. Findings include: Please see Tags Y0085, Y0450, Y0590, Y0593, Y0878, and Y0920. Severity: 2 Scope: 3	0050	1. Administrator reviewed all requirements for compliance especially in the areas noted in this notice of deficiency. 2. Improve the implementation of complying with the requirements for personnel and residents care 3. This is a continuing process and documentation of progress or compliance will be an ongoing tasks 4. Administrator 5. 3/31/2022 6. no document attached	04/01/2022
0085 SS= F	Staffing - Cg on Duty All Times - NAC 449.199 Staffing requirements 1. The administrator of a residential facility shall ensure that a sufficient number of	0085	1. Reviewed schedule and met with all employees, discuss their duty to: 1) come as scheduled 2) follow the company policy of calling in at least 4 hours before schedule	03/31/2022

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	caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. Inspector Comments: Based on interview and document review, the facility failed to ensure residents were not left with no caregiver in the facility. Findings include: On 09/15/21 at 9:47 PM, Caregiver #3 explained on 09/13/21, Caregiver #1 was on duty and had left the facility at 8:49 PM. There were no caregivers present in the facility when Caregiver #1 left the facility. At approximately 11:00 PM, a resident called the police to report no caregiver in the facility. The Owner was notified there was no caregiver in the facility by the responding police. The Owner explained to the police officer another caregiver would be at the facility within 30 minutes; however, the caregiver did not show up. Caregiver #2 verbalized the police officer was tending to residents in the facility by helping them to their rooms and providing them beverages. The police officer searched the entire facility and could not locate a caregiver present in the facility. The police officer called the Owner a second time to inform the Owner the caregiver had not arrived at the facility. Caregiver #2 explained at 09/13/21 at 2:08 AM, Caregiver #2 arrived at the facility. On 09/15/21 at 10:18 PM, Caregiver #2 explained Caregiver #2 was supposed to start their shift on 09/13/21 at 8:00 PM, however Caregiver #2 had called Caregiver #1, who was on duty, to let the facility know Caregiver #2 would not be able to come to work on 09/13/21, because they were running a fever. Caregiver #1 acknowledged Caregiver #2 called out sick. Caregiver #2 explained they were surprised when they received a call from the Owner at approximately 2:00 AM on 09/13/21, explaining the residents were left alone in the facility. The Owner informed Caregiver		to ensure availability of replacement or substitute 3) reduced number of hours for penalty for not calling in ahead of time and for leaving the floor without a replacement. 2. Change in policy: cut back hours when not following rules (per 1) and possible suspension 3. Time cards are used to monitor attendance and tardiness; this will be carried on as a report during the monthly meetings. 4. The Administrator 5. Effective today, 3/31/2022 6. Attached document summarized what happened during the incident. For general information, there is one caregiver who lives in the facility to ensure that at no-time will the facility have no caregiver.	

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	#2 to go to the facility, sick or not. Caregiver #2 arrived at the facility shortly after 2:00 AM and observed a police officer in the facility. Caregiver #2 explained the situation to the police officer who then left the facility. On 09/24/21 at 8:50 AM, the Owner recalled receiving a phone call from Caregiver #1 at 8:49 PM. Caregiver #1 had informed the Owner no caregivers were in the building; however, Caregiver #1 explained they were leaving anyways. The Owner admitted knowing the residents were left alone at the facility on 09/13/21, and not doing anything to ensure a caregiver was present. The Owner recalled receiving a call from a police officer at around 11:00 PM informing the Owner there was no caregiver in the building. The police officer told the Owner every room was searched in the facility and a caregiver could not be located. The Owner informed the police officer a Caregiver would arrive at the facility in 30 minutes. The Owner explained they did not come to the facility themselves because they were 45 minutes away. The Owner received a phone call from the police officer a second time informing the Owner the Caregiver never showed. The Owner then called Caregiver #2 and instructed Caregiver #2 to go to the facility. The Owner admitted having knowledge Caregiver #2 had a fever; however did not care and told the Caregiver to show up at the facility. Caregiver #2 clocked in at 2:09 AM. The Owner confirmed all residents were left alone, without supervision in the facility, from 8:49 PM to 2:09 AM. The owner confirmed they had knowledge the residents were left alone and did not act accordingly to ensure proper supervision. The Owner confirmed all residents were without caregiver supervision for over three hours, resulting in a police report being filed. The timecard for Caregiver #1 documented on 09/13/21, the end of their shift was at 8:49 PM. The timecard for Caregiver #2 documented on 09/13/21, the beginning of their shift was at 2:09 AM. The			

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	timecards lacked documentation there was a Caregiver on shift on 09/13/21, between the hours of 8:49 PM and 2:09 AM. The Staffing Schedule dated September 2021, documented two caregivers were scheduled to be on graveyard shift on 09/13/21. The Chronical of Events dated 09/14/21, documented on the night of 09/12/21 through the early hours of 09/13/21, the following events occurred: -At 8:45 PM on 09/12/21, Caregiver #1 had called the Owner and informed the Owner, Caregiver #1 was leaving the facility and no caregiver would be present. -At 10:46 PM, Caregiver #1 had texted the Owner regarding Caregiver #2 not showing up for their shift and the Owner assumed there was a Caregiver in the building. -At 11:41 PM, the Owner received a phone call from a police officer informing the Owner there was not a caregiver on the premises. -At 11:47 PM, the Owner called Caregiver #2 and left a message. -At 11:50 PM, the Owner called Caregiver #2 again with no answer. -At 11:50 PM, the Owner called Caregiver #4 with no answer. -At 11:56 PM, the Owner called Caregiver #2 with no answer. -At 11:57 PM, the Owner spoke with Caregiver #4 who stated they could be at the facility in 45 minutes. -On 09/13/21 at 12:06 PM, the Owner spoke to Caregiver #2 who informed the Owner they had a fever but would come to the facility. -At 12:08 AM, the Owner informed the police officer a caregiver would be at the facility in 10 to 15 minutes. -At 1:23 AM, Caregiver #2 informed the Owner, Caregiver #2 had arrived at the facility. Severity: 2 Scope: 3 Complaint #NV00064847			

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on document review and interview, the facility failed to ensure 1 of 11 employees obtained a tuberculosis (TB) screening (Employee #4). Findings include: Employee #4 Employee #4 was hired at the facility on 07/13/19 as a Caregiver. Employee #4 personnel file documented a two-step TB. The first step was read on 07/06/19 and the second step was read on 07/13/19. Employee #4 personnel file lacked documented evidence of an annual TB test completed for 2020. On 11/03/20 at 11:14 AM, the Assistant Manager confirmed there was no TB test completed for Employee #4 in 2020 and verbalized an annual TB test was required to ensure the safety of all residents in the facility. Severity: 2 Scope: 1	0102	1. Reviewed all records to ensure that all annual TB tests for employees were completed 2. Supervisor made a tabulation for annual dates for each employee Employee records are reviewed before conducting the annual performance review 3. Document dates of performance review and records review 4. Administrator or Supervisor 5. 3/31/2022 6. no document submitted Note: employee #4 is no longer employed	03/31/2022
0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure resident rooms remained free of bedbugs. Findings include: On 10/23/20 at 9:50 AM, in resident's Wing B Room 2, a dead bedbug was on the floor. On 10/23/20 at 10:16 AM, in resident's Wing B Room 4, a dead bedbug was on the floor. On 10/23/20 at 11:02 AM, on the semi-private room wing	0174	1. All bed bugs sightings have been corrected by Orkin Pest Control treatment 2. The practice that minimized or eliminated the bed bugs: 1) after each shower- all beddings are removed, washed and changed . 2) This is a change from the practice of changing the beddings weekly unless it is soiled. Note that clients are scheduled for shower 2-3 times a week 3. This is randomly checked since this is already a routine practice and the clients also expect a new change each time they are showered. 4. Supervisor or Med Tech for the shift. 5. documented today but has been practiced routinely for over a year. 6. no document needed.	03/31/2022

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		A. BUILDING _____ B. WING _____	**09/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

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	in room 3, there was two dead bed bugs under the bed. On 10/23/20 at 11:14 AM, on the semi-private room wing in room 9, there was dead bed bug by the window. On 10/23/20 at 11:32 AM, on resident's Wing A Room 1, four dead bugs were in the crevice of the bed mattress. On 10/23/20 at 12:05 PM, on resident's Wing A Room 8, a live bed bug was crawling on the floor. On 10/23/20 at 12:32 PM, on resident's Wing A Room 11, a live bed bug was on the sheets of the bed. On 10/23/20 at 12:36 PM, the Administrator Designee observed and confirmed a bed bug was alive in Wing A Room 11, on a resident's bed. On 10/23/20 at 12:44 PM, the Administrator Designee explained a pest control company had come to the facility to spray for bed bugs; However, the company was only hired to spray in the living room. On 10/23/20 at 1:46 PM, the Administrator Designee verbalized the facility had received a contract to have the pest control company come out the following week to treat three rooms. On 10/23/20 at 1:46 PM, the Administrator Designee confirmed in Wing A Room 1, four dead bugs were in the crevice of the bed mattress. The pest control company invoice, dated 10/27/20, indicated the company had treated rooms A8, A11, and B11 for bed bugs to include the bed frames, baseboards, television stands, night stands, closets, dressers, and bathrooms. On 10/29/20 at 9:30 AM, the Administrator Designee confirmed the pest control had treated the three rooms for bed bugs on 10/27/20. The Administrator Designee verbalized the pest control company was returning the following day to treat rooms A1, A3, and A7 for bed bugs. On 10/29/20 at 10:16 AM, in the hot water heater room, there were two dead bed bugs. On 10/29/20 at 10:17 AM, on resident's Wing A Room 11, there were four dead bed bugs on the floor. On 10/29/20 at 10:23 AM, on resident's Wing A Room 8, there were four dead ants, two dead bed bugs, and one dead spider on the floor. On			

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	10/29/20 at 10:39 AM, a Caregiver verbalized having seen live bedbugs in Wing A Room 11 and a couple of days ago, had seen bed bugs in a semi private room. Severity: 2 Scope: 3			
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation and interview, on 09/24/21, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446 to ensure kitchen staff wore masks, hairnets, and gloves, and performed hand hygiene while preparing food in the kitchen. Findings include: On 09/24/21 at 8:22 AM, a Cook in the kitchen prepared ham and cheese sandwiches for resident lunches without a mask, hairnet, and gloves. The cook took an item into the walk-in refrigerator then returned to the kitchen to continue making ham and cheese sandwiches and did not perform hand hygiene in the handwashing sink. On 09/24/21 at 9:05 AM, the Supervisor verbalized kitchen staff should wear masks, gloves, and hairnets in the kitchen and perform hand hygiene in the handwashing sink before and after preparing food. On 09/24/21 at 9:41 AM, the Cook verbalized the Cook should wear a mask, hairnet, and gloves when preparing food in the kitchen. The Cook admitted the Cook was not wearing a mask, hairnet, or gloves while making sandwiches for the resident lunches. The Cook confirmed hand hygiene should be performed after leaving the preparation area in the kitchen, before returning to prepare food. The Cook explained the Cook washed their hands in the dishwashing sink before returning to the	0255	1. The rules for the kitchen were reviewed with the employees who are involved in the kitchen tasks Note: the cook observed during the inspection quit that day. 2. will send cooks for training in Kitchen Rules 3. training will be documented 4. Administrator is responsible for this compliance and will follow up. 5. 5/31/2022 cooks to be retrained 6. will attach training docs when completed	05/31/2022

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	kitchen preparation area to continue to make sandwiches. The Cook admitted the handwashing sink was available andverbalized the dish sink was sufficient to perform hand hygiene. On 09/24/21 at 9:50 AM, the Owner verbalized the expectation was staff wear a mask, hairnet, and gloves when preparing food in the kitchen and perform hand hygiene in the sink designated for hand washing. The Owner confirmed the Cook should not perform hand hygiene in the sink for dish washing. The Owner explained it was important for the Cook to wear a mask, hairnet, and gloves, and perform hand hygiene in the designated hand washing sink while preparing food to prevent cross contamination. Severity: 2 Scope: 2			

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0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on document review and interview, the facility failed to ensure 1 of 11 employees was currently certified to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #10). Findings include: Employee #10 Employee #10 was hired at the facility on 09/14/20, as a Restorative Aide. Employee #10's personnel file lacked documented evidence the employee had a current CPR and First Aid certification. Employee #10 was on the October and November 2020 staffing schedules, working with residents. On 11/03/20 at 11:09 AM, the Assistant Manager confirmed Employee #10 lacked evidence of certification for CPR and First Aid. Severity: 2 Scope: 1	0450	1. Note the employee in question is no longer employed. Send employees for CPR/First Aid training within 30 days of employment 2. Pay structure now includes an orientation rate for the first 30 days, subject to increase upon completing the CPR/FA training. 3. Monitored by record review and pay review 4. Administrator 5. 3/31/2022 6. no document attached	03/31/2022
0590 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on interview, the facility failed to ensure a resident was not neglected for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility	0590	1. Findings involved a client wanting to have her shower during the day - and schedule to be followed for 2-3 times a week. Showers are scheduled for every client 2-3 times a week. This schedule is followed. However, the client involved was a special case: a 2 person assist who requires at least 45 minutes to complete a shower. Besides after shower, this client wants to have additional time with the caregiver in her room to do other nonroutine stuff, like arranging her things over and over again in different positions. The Administrator discussed with her the situation and made an agreement with her that her shower be done at 7pm in order to be able to have dedicated time without any	11/01/2021

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	on 03/02/21, with diagnoses including chronic incomplete quadriplegia, insomnia and anxiety. On 09/15/21 at 9:25 PM, Resident #1 verbalized Resident #1 was waiting to receive their shower for the day. The resident explained the resident had only received two showers in the last three weeks and was care planned to have three showers per week, on every Monday, Wednesday, and Friday. The resident verbalized the resident went without showers because the facility was short staffed. The resident tearfully verbalized the resident felt neglected and forgotten. The resident had notified various staff members the resident would like to be showered more frequently, however the resident was told because the resident was a two person lift, there were not enough caregivers to lift the resident out of bed and take the resident to the shower room. On 09/15/21 at 9:44 PM, a Caregiver verbalized Resident #1 had not been showered because the Caregiver did not have time. The Caregiver confirmed Resident #1 should receive showers three times a week, every Monday, Wednesday, and Friday. The Caregiver admitted Resident #1 did not always get showered three times a week because the facility was short staffed. The Shower Schedule for Resident #1 documented the resident was to receive a shower on Monday, Wednesday, and Sunday. On 09/24/21 at 8:50 AM, the Owner explained Resident #1 would ask for showers and the Owner would inform Resident #1 they could not have a shower and to not ask again. The Owner confirmed Resident #1 had not been receiving showers and could not explain how often Resident #1 was supposed to receive showers. The Owner explained telling the resident no on showers because if a Caregiver were to be pulled from the floor to give Resident #1 showers, the other residents would not receive the care they request because the Caregiver would not be available. The Owner admitted telling the resident 'no' was a violation of		hurry. Unfortunately, the client would insist in having a shower in mid afternoon when everyone is getting ready for dinner. She preferred to have only one worker to shower her and the worker told me that he want others to take turns in doing the shower. The client would insist on having her shower with only this worker. The administrator explained to her the situation and discussed with the the possibility of looking for another facility for this is the only schedule we can give her. She made arrangements to move. She gave me a 30 day notice. The complaint was done on 9/15 and she made all arrangements to moveout. She left on Nov1, 2021. 2) Complaints and grievances and response are addressed as soon as this is reported or learned by management (Administrators, Supervisor and Staff). A documentation using the Incident Report form maybe used and/or a note is written on the Communication Book. 3) A meeting reviewing the residents rights was conducted by the administrator to all members of the staff. The elder abuse training sheets were reviewed. In particular: a) residents are not to be abused or neglected. that there needs are met. b) staff was told to report immediately any complaint or request not met so the Supervisor or the Administrator can resolve the issue. c) the administrator will discuss with the resident concerned any solution or resolution until needs are met to the satisfaction of the resident. d) the Administrator will involve any resident family or guardian or social worker to resolve this issue. (Note : in this particular case, prior to the complain date, there have been discussions between the Administrator and her Medicaid social worker regarding the possibility of moving her out of the facility. The social worker was instrumental in her	

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	their rights. The Owner confirmed Resident #1 was often not assisted out of bed because there were not enough caregivers to help assist the resident. The Owner verbalized there were not enough staff on shift to help all residents with their needs and leaving Resident #1 in bed with no assistance was neglectful and against resident rights. Severity: 2 Scope: 1 Complaint #NV00064847		planning to move and finding the best arrangement such that her Medicaid program will continue without any interruption) 4. The Administrator is in charge in following up complaints, investigating any reported abuse or neglect. 5. This deficiency was corrected on 11/1/2021 6. no document attached	
0593 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on observation, interview, and document review, the facility failed to provide a safe environment for 30 of 30 residents by 1) not ensuring proper disinfectant and cleaning products were used for resident rooms positive for COVID-19 2) proper Personal Protective Equipment (PPE) was worn by staff and residents 3) ensure proper	0593	I am addressing the issues one at a time: Exit Doors: There doors have no locks. They are equipped with alarms that sounds on- when the door is pushed from the inside. There are no knobs on the doors nor any provision for locks. Photos attached. Training: 1. There was no opportunity to show or review our training regarding COVID protocols. Attached is our training summary for 2020 and 2021. CDC rules or guidelines were provided and taught to the staff when the rules were available. See attached training summaries:	03/31/2022

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	isolation precautions were followed for COVID-19 positive residents 4) ensure proper training was completed for staff regarding infection control measures for COVID-19 and 5) exit doors remained unlocked. Findings include: Infection Control On 09/15/21 at 9:00 PM, upon entry, two Caregivers were in the kitchen without a mask on and three residents in the common area next to the kitchen were not wearing a mask. On 09/15/21 at 9:08 PM, the Caregivers denied not wearing a mask. On 09/15/21 at 9:08 PM, a Caregiver explained there was currently one resident showing signs and symptoms of COVID-19, however the resident had not been tested. The Caregiver verbalized there were two residents who had gone to the hospital positive for COVID-19 and had since returned to the facility. The Caregiver explained both residents were currently isolating in their room. Isolating the residents meant the residents were not allowed to leave their rooms and had to wear a mask at all times to prevent the spread of COVID-19. On 09/15/21 at 9:18 PM, the first isolation room for Resident #3 had a PPE cart outside of the door and the resident's door was open. Resident #3 was standing in the doorway, without a mask. Located on the PPE cart was a package of aloe wipes, one box of gloves and one gown. Next to the PPE cart were two used gowns hung on the assist bar on the wall. On 09/15/21 at 9:18 PM, the Caregiver verbalized Resident #3 was in isolation, should have been wearing a mask and the resident's door should have been shut. The Caregiver confirmed the resident on isolation for COVID-19 was not wearing a mask and had their door open to the hallway. The Caregiver explained there could be a spread of COVID-19 in the facility by not ensuring the resident was wearing a mask and the resident had their door closed. The Caregiver verbalized the two gowns on the assist bars in the hallway had been used by caregivers entering the		1. Keeping the place safe was noted in reference to the improper use of cleaning and disinfectants at the clients' rooms. This has been corrected by using the proper disinfectants and proper ppe provided to the staff. 2. Review the protocol for isolating clients having a contagious disease such as COVID. 3. Review the protocol of monitoring client temperatures each shift. All of these are documented. 4. Supervisor reviews the data.	

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	room and the gowns should have been disposed of immediately after use. The Caregiver confirmed there were two soiled gowns hanging on the assist bar in the hallway. On 09/24/21 at 8:50 AM, the Owner verbalized residents positive or presumptive with COVID-19 needed to be in isolation to prevent the spread of COVID-19 to the other residents. The rooms on isolation were supposed to keep their door closed, residents were to have a mask on their face covering their nose and mouth, proper PPE was to be used by staff caring for the residents and proper disinfectants recommended by the Centers for Disease Control (CDC) were to be used. The Owner explained there was not a dedicated isolation unit in the facility. If a resident were to be tested positive for COVID-19, they would only isolate the resident's room. Staff were to don an N95 mask, gloves and a gown prior to entering the isolation room. In addition, since there was COVID-19 positive residents in the facility, all staff and residents were to wear a surgical mask while out in common areas of the facility. When disinfecting high touch surfaces, proper disinfectant cleaning products were to be used. The cleaning products used in the facility were aloe wipes, Pine Sol and bleach. The Owner verbalized the cleaning products used to clean the facility were all efficient disinfecting products and would kill COVID-19 bacteria on surfaces. Staff were trained on all CDC guidelines to include proper hand hygiene, how to properly don and doff PPE, types of PPE to use, and what symptoms to check for related to COVID-19. The Owner explained the symptoms to look for were a fever and diarrhea. If a resident were to exhibit those signs and symptoms, the resident would be sent to the emergency room for testing and evaluation. If the resident tested positive, then upon return to the facility, the resident would be isolated for 14 days. The Owner was not able to produce training modules and a curriculum for training staff related to			

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	COVID-19 precautions. Locked Exit Door On 09/20/21 in the morning, a resident located in a room next to the emergency exit verbalized they would parish if there was a fire in the facility and the door was always locked. On 09/20/21 at 10:42 AM, the Manager confirmed the emergency exit was locked and in case of an emergency all residents would be trapped in the facility. The facility's posted evacuation plan indicated room #8 and room #10 outside doors were emergency exits and the door on the south side of the facility was an emergency exit. Severity: 2 Scope: 3 Complaint #NV00064847			