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 _____ | **05/03/2022** |

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

| (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 |
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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory grading re-survey and complaint investigation, State Licensure survey completed at your facility on 05/03/22. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 38 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 28. Twelve resident files were reviewed and nine employee files were reviewed. Your facility has received a D grade for this inspection. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. There were eight complaint investigations conducted on survey. Complaint #NV00065920 with the allegation of staff not wearing masks in the facility per infection control protocol was substantiated (see Tag Y0593). Complaint #NV00066129 with the following allegations was substantiated. Allegation #1: No food menu posted (See Tag Y0272). Allegation #2: Medication Administration Records (MAR) were initiated by staff prior to the administration of medications (See Tag Y0895). Allegation #3: Staff did not wear masks in the facility (See Tag Y0593). The following allegations could not be substantiated due to a lack of evidence: | 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AFRODESIA LOPOZ Title: Administrator Date: 07/06/2022

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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| | Allegation #4: Resident bathrooms were filthy. Allegation #5: Resident room floor was dirty with trash on the floor. Allegation #6: Facility was short staffed. Allegation #7: MAR documentation missing staff initials. Allegation #8: Medication not on site. The investigation into the allegations included: Observation of resident rooms, resident bathrooms, medication room, staff providing care to residents, staff working the floor and dining services provided to residents. Interviews were conducted with the Manager, a Housekeeper, two Caregivers, a Medication Technician and four residents. Document review included MAR, incident reports, staff shift coverage, physician orders, housekeeping schedules, and food menus. Complaint #NV00065228 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: A resident's room smelled strongly of urine. Allegation #2: A resident's room had feces on the floor and wall. Allegation #3: A resident's room had dried blood on the wall. The investigation into the allegations included: Observation of resident rooms, resident bathrooms, odors in the facility, staff providing care to residents, staff working the floor and housekeeping cleaning resident rooms. Interviews were conducted with the Manager, a Housekeeper, two Caregivers, a Medication Technician and four residents. Document review included incident reports, staff shift coverage and housekeeping schedules. Complaint #NV00065138 with the allegation of staff not wearing masks in the facility per infection control protocol was substantiated (See Tag Y0593). Complaint #NV00065371 with the allegation the facility did not post a menu was substantiated (See tag Y0272). The following allegations could not be substantiated due to lack of evidence. Allegation #1: A resident did not receive assistance from staff with transferring to a chair due to lack of staff. Allegation #2: A resident was left in the resident's bed on weekends and was | | | |

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| | unable to get up by themselves. The investigation into the allegations included: Observation of residents being assisted by staff with ambulation and transfers. Interviews were conducted with three residents, including a resident of concern, two Caregivers, and the Facility Supervisor. Complaint #NV00066191 with the allegation the facility refused to call for an ambulance when a resident requested to be transported via ambulance to an emergency department after a fall with injury was substantiated (See tags Y0850 and Y0595). Complaint #NV00065596 was substantiated. The allegation a resident had a wound not treated was substantiated (See tags Y0620 and Y0878). The following allegations could not be substantiated due to a lack of evidence: Allegation #1: The facility had bed bugs. Allegation #2: Employee to resident abuse. The investigation into the allegations included: Observation of resident rooms, resident mattresses, facility linen closets, employee to resident interactions in the dining room, the hallways, and resident rooms. Interviews with four residents, the Administrator, and a Caregiver. Review of a resident with wounds clinical documentation. Review of the facility pest control contracts and service dates. Complaint #NV00062569 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: The facility had bed bugs. Allegation #2: Employees were impaired while working. The investigation into the allegations included: Observation of resident rooms, resident mattresses, facility linen closets, employee to resident interactions in the dining room, the hallways, and resident rooms. Interviews with three residents, two Caregivers, and the Administrator. Review of the facility pest control contracts and service dates. 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 | | | |

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| | investigations, 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: | | | |
| 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.<br><br>Inspector Comments: Based on observation, document review, record review and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision. Findings include: Please see TAGs Y0065, Y0074, Y0102, Y0104, Y0106, Y0174, Y0178, Y0272, Y0335, Y0515, Y0593, Y0595, Y0620, Y0850, Y0878, Y0895, Y0920, and Y0936. Severity: 2 Scope: 3 | 0050 | 1. A review of the citation for the Administrator's oversight showed 5 of the cited regulation is on Personnel File and Recordkeeping. This is for Tag 0065,0074,0102,0104,0106 .A record review and oversight is being conducted.<br>A review of the citation for the Administrator's oversight showed 3 on building maintenance (0174,0178,0179.<br>A review of the citation for the Administrator's oversight showed 7 on resident's record on MARS and responses to medical needs.<br>A review of the citation for the Administrator's oversight showed the rest on miscellaneous use of management of the rooms etc.<br>2. Recordkeeping has been reviewed by the Administrator and the Supervisor. A system of check and balance now include the night shift person to be involved in the review so that any error can be corrected on a timely manner.<br>Maintenance of the building is under review; whether to hire a regular or part time maintenance or to contract as needed.<br>Policies in managing the care or needs of the residents is also under review. To date:<br>a) changes or awareness of the completeness of a TB screening<br>b) keeping the Administrator's file available (since the Administrator is the owner at the same time) there was reluctance in having personal files available to staff. This will be corrected and files will be made available.<br>c) immediate maintenance to items that are unsafe to residents and staff.<br><br>The Administrator is responsible in complying with all the requirements to operate the facility safely and in compliance with the regulations. | 06/15/2022 |
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| 0065 SS= F | Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.<br><br>Inspector Comments: Based on employee file review, document review and interview, the facility failed to ensure 7 of 7 sampled employees obtained eight hours of annual caregiver training (Employee #1, #2, #3, #5, #6, #8, and #9). Findings include: Employee #1 Employee #1 was hired as a Medication Technician with a start date of 12/19/08. Employee #1's personnel file documented six hours of annual caregiver training in 2021. Employee #1's personnel file lacked documented evidence of an additional two hours of annual caregiver training to meet the required eight hours of annual caregiver training requirement. Employee #2 Employee #2 was hired as a Medication Technician with a start date of 12/08/19. Employee #2's personnel file documented six hours of annual caregiver training in 2021. Employee #2's personnel file lacked documented evidence of an additional two hours of annual caregiver training to meet the required eight hours of annual caregiver training requirement. Employee #3 Employee #3 was hired as a Medication Technician with a start date of 02/01/19. | 0065 | 1. The Training Records were misread. The summary sheet for 2021 indicated a total of 7 hours classroom and 2 hours of nonclassroom or on the job as documented in the training notes. Attached is the summary with notation. The training on the job was on important and relevant topics on CDC Guidelines and SOR Policy on Reporting incidents, originally discussed in 2020 (COVID) and repeated on the job for emphasis ofimplementation.<br>2. We will revise our recordkeeping to avoid confusion and to reflect actual hours in each record on file.<br>a) we will accurately record on the job training versus "classroom training"<br>b) we will accurately show the dates of employment for employees who leave work for months and then come back to work. This lapse in training due to unemployment months is confusing to the counting of hours required for training. When an employee does no work for months (she misses the regular training during those months).<br>c) Employee #9, the Administrator is the trainer so she has all the hours, but we will revise the recordkeeping to clearly reflect the amount of training received or conducted.<br>3. Training records since 2020 have been summarized as the training goes on. This monthly recordkeeping helps keep track of the hours of training.<br>4. Additional training and needs are being reviewed for all. We will review and conduct all additional training for all on or before July 31.<br>5. The Administrator is in charge of this task. | 07/15/2022 |

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| | Employee #3's personnel file documented two hours of annual caregiver training in 2021. Employee #3's personnel file lacked documented evidence of an additional six hours of annual caregiver training to meet the required eight hours of annual caregiver training requirement. Employee #5 Employee #5 was hired as a Caregiver with a start date of 05/08/20. Employee #5's personnel file documented one hour of annual caregiver training in 2021. Employee #5's personnel file lacked documented evidence of an additional seven hours of annual caregiver training to meet the required eight hours of annual caregiver training requirement. Employee #6 Employee #6 was hired as a Caregiver with a start date of 01/01/21. Employee #6's personnel file documented six hours of annual caregiver training in 2021. Employee #6's personnel file lacked documented evidence of an additional two hours of annual caregiver training to meet the required eight hours of annual caregiver training requirement. Employee #8 Employee #8 was hired as a Medication Technician with a start date of 12/19/08. Employee #8's personnel file documented six hours of annual caregiver training in 2021. Employee #8's personnel file lacked documented evidence of an additional two hours of annual caregiver training to meet the required eight hours of annual caregiver training requirement. Employee #9 was hired as the Administrator with a start date of 01/01/03. Employee #9's personnel file lacked documented evidence of eight hours of annual caregiver training in 2021. On 05/03/22 at 11:21 AM, the Supervisor was unable to provide evidence of additional annual caregiver training had been completed for Employees #1, #2, #3, #5, #6, #8 and #9. The Supervisor confirmed there was no additional training documentation on-site and/or was not aware of where any additional training documentation was located. Severity: 2 Scope: 3 | | | |
| 0074 | Elder Abuse Training - NRS 449.093 | 0074 | 1. There must be a mistake in identifying | 06/13/202 |

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| SS= D | 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 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 | | the records for Employee #3. Employee #3 was hired since 2019 and her elder abuse training is complete each year with the correct date and year. Attached are the elder abuse files for employee $3.<br>For Employee #9 (Administrator and Employer) the Administrator conducts the Elder Abuse Training for all employees, upon hiring or for annual review. The Administrator also takes the online training on elder abuse, a requirement for renewing the Administrator's license every other year. unfortunately this training has not been clearly documented. To comply, attached is the latest elder abuse training record for employee #9.<br>2. Elder Abuse training for the Administrator (Employer) will be filed annually just like any employee file.<br>3. The Administrator is responsible for compliance with this requirement. | 2 |

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| | 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 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 | | | |

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| | 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.<br><br>Inspector Comments: Based on document review, record review and interview, the facility failed to ensure 2 of 9 sampled employees had initial or annual elder abuse prevention training (Employee #3 and #9). Findings include: The facility's Plan of Correction (POC), dated 11/04/20, documented, "the Administrator will not hire a worker without an elder abuse training completed and will review the records annually during their performance review." Employee #3 Employee #3 was hired as a Caregiver with a start date of 09/10/21. Employee #3's personnel file contained a initial elder abuse prevention training post test, dated 01/20/21. Employee #3 did not complete the elder abuse prevention training prior to being scheduled to work in the facility with residents. Employee #9 Employee #9 was hired as the Administrator with a start date of 01/01/03. Employee #9's personnel file lacked documentation of annual elder abuse prevention training for 2020 and 2021. On 05/03/22 at 11:24 AM, the Supervisor was unable to locate elder abuse training in the Employee #3's and #9's file and further expressed not being able to locate the training in a different area in the office. The Supervisor confirmed the training was not on-site and/or was not aware of where the training document was located. Severity: 2 Scope: 1 | | | |
| 0102 SS= E | Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as | 0102 | 1. This citation on the TB reading- time and other TB requirements is under review with | 07/01/2022 |

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| | 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;<br><br>Inspector Comments: Based on employee file review, document review and interview, the facility failed to ensure a tuberculosis (TB) screening was completed within the required timeframe for 4 of 9 sampled employees (Employee #4, #6, #8 and #9). Findings include: Employee #4 Employee #4 was hired as a Caregiver with a start date of 09/10/21. Employee #4's employee file documented a two-step TB test with the first step given on 08/31/21 at 12:30 PM and read negative on 09/02/21 at 12:41 PM and the second step given on 09/07/21 at 10:15 AM and read negative on 09/10/21 at 12:15 PM. Employee #4's second step TB test was read more than 72 hours after it was given. On 05/03/22 at 11:17 AM, the Supervisor confirmed Employee #4's second step TB test was not read timely and Employee #4's two step TB test was not considered complete prior to employment. Employee #6 Employee #6 was hired as a Caregiver with a start date of 01/01/21. Employee #6's employee file documented an annual TB test given on 02/18/22 at 9:00 AM and read negative on 02/21/22 at 11:30 AM. Employee #6's annual TB test was read more than 72 hours after it was given. On 05/03/22 at 11:21 AM, the Supervisor confirmed Employee #6's annual TB test was not read timely and Employee #6's TB test was considered incomplete for employment. Employee #8 Employee #8 was hired as a Medication Technician with a start date of 08/01/10. Employee #8's employee file documented an annual TB test given on 10/08/21 at 11:30 AM and read negative on 10/11/21 at 2:00 PM. Employee #8's annual TB test was read more than 72 hours after it was given. On 05/03/22 at 11:13 AM, the | | our clients. The readings of few minutes over 72 hours is an issue since going to and from the doctor's office for reading may not be done exactly on time. Attached is the TB skin test conducted for employee #9 (Administrator/Employer)<br>2. For clients, we now require the Blood Test Quantiferon TB test. For the employees, we will monitor the reading times for the skin tests.<br>Upon further inquiry from medical professionals the readings may be made between 48 and 72 hours. This knowledge will assist us in informing employees when to go for the skin-readings.<br>3. Records will be reviewed upon receipt of test results for completeness and compliance.<br>All records will be reviewed and corrected for TB compliance by July 1.<br>The Supervisor will monitor compliance. | |

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

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| | Supervisor confirmed Employee #8's annual TB test was not read timely and Employee #8's TB test was considered incomplete for employment. Employee #9 Employee #9 was hired as the Administrator on 01/01/03. Employee #9's employee file documented a TB test given on 02/26/18 and read negative on 02/28/18. Employee #9's employee file lacked documented evidence a two-step TB test had been completed to ensure TB compliance for employment, since 2018 On 05/03/22 at 11:21 AM, the Supervisor confirmed Employee #9's personnel file lacked documented evidence of current annual TB testing and verbalized not being able to locate the TB testing in a different area in the office. The Supervisor confirmed the TB testing was not on-site and/or was not aware of where the TB testing document was located. Severity: 2 Scope: 2 | | | |
| 0104 SS= E | 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.<br><br>Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 4 of 9 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.124 (Employee #4, #5, #8 and #9). Findings include: Employee #4 Employee #4 was hired at the facility as a Caregiver with a start date of 09/10/21. Employee #4's personnel file documented fingerprints taken on 08/31/21 but lacked evidence of a Criminal History Statement and a Nevada Automated Background Check System (NABS) clearance letter. On 04/27/22 at 2:50 PM, NABS documented Employee #4 was not listed on the roster for the facility. On 05/03/22 at 11:17 AM, the Supervisor confirmed Employee #4's | 0104 | 1. We reviewed all fingerprint records and clearances. Attached is the submittal for employee #4 and for #5, we wait for the response on updated roster. The Administrator's fingerprint clearance is monitored by BELTCA every time the license is renewed. Employee #8 due for renewal (after 5 years) is waiting for his records. We will complete all reviews by July 15.<br>Attached current roster; will print clearance when available.<br>The Administrator is in charge of this task. | 07/15/2022 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | personnel file lacked documented evidence of a Criminal History Statement and a NABS clearance letter for the facility and Employee #4 was scheduled to work in May 2022. Employee #5 Employee #5 was hired at the facility as a Caregiver with a start date of 05/08/20. Employee #5's personnel file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 04/27/22 at 2:50 PM, NABS documented Employee #5 was not listed on the roster for the facility. On 05/03/22 at 11:19 AM, the Supervisor confirmed Employee #5's personnel file lacked documented evidence of fingerprints and was scheduled to work in May 2022. Employee #8 Employee #8 was hired by the facility as a Medication Technician. Employee #8's personnel file documented a NABS clearance letter dated 02/09/17. Employee #8's personnel file lacked documented evidence of a five year renewal set of fingerprints submitted to the Central Repository for Nevada Records of Criminal History and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 04/27/22 at 2:50 PM, NABS documented Employee #8 was listed eligible-expired on the roster for the facility. On 05/03/22 at 11;13 AM, the Supervisor confirmed Employee #8's NABS was expired, had not been renewed and Employee #8 was scheduled to work in May 2022. Employee #9 Employee #9 was hired by the facility as the Administrator with a start date of 01/01/03. Employee #9's personnel file lacked documented evidence of a five year renewal set of fingerprints submitted to the Central Repository for Nevada Records of Criminal History and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 04/27/22 at 2:50 PM, NABS documented Employee #9 was not listed on the roster for the facility. On 05/03/22 at 11:21 AM, the Supervisor confirmed Employee #9's | | | |

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| | personnel file lacked documented evidence of a Criminal History Statement and a NABS clearance letter for the facility. The Supervisor confirmed there was no additional NABS documentation on-site and/or was not aware of where any additional NABS documentation was located. Severity: 2 Scope: 2 | | | |
| 0106 SS= D | Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation;<br><br>Inspector Comments: Based on employee personnel file review and interview, the facility failed to ensure 1 of 9 sampled employees (Employee #9) maintained current certification in cardiopulmonary resuscitation (CPR) and first aid training. Findings include: Employee #9 Employee #9 was hired as the Administrator with a start date of 01/01/03. Employee #9's personnel file documented CPR and first aid training, dated 01/07/19 with an expiration date of 01/31/21. Employee #9's personnel file lacked documented evidence of current CPR and first aid certification. On 05/03/22 at 11:21 AM, the Supervisor acknowledged Employee #9's CPR and first aid training certification was not current and verbalized not being able to locate a current CPR and first aid certification in a different area in the office. The Supervisor confirmed the CPR and first aid certification was not on-site and/or was not aware of where the CPR and first aid certification was located. Severity: 2 Scope: 1 | 0106 | 1. The recertification for the Administrator's card is current. The card was not on file. Attached is the card, with an expiration date of 1/2023. Attached.<br><br>2. The Administrator's binder is not made available to all staff since the Administrator is also the owner. Personal information are kept away from the staff.<br><br>3. I will isolate records and place on file the following: Training records and First Aid and other non-personal type records.<br>The Administrator is responsible for compliance.<br><br>NOTE: as of July 6, 2022, a new First Aid & CPR training certificate was obtained and uploaded per email instructions 6/28/2022. | 06/15/2022 |

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 |
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| 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.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure the common areas and hallways were free from safety hazards. This deficient practice could affect all residents, staff, and visitors. Findings include: On 05/03/22 at 8:56 AM, the corner of the wall entering the corridor next to the kitchen and the corner outside Room 5-6 contained a piece of metal pulled up to an approximately 90-degree angle. On 05/03/22 at 8:56 AM, the Caregiver confirmed the protruding metal could cause harm. Severity: 2 Scope: 3 | 0174 | 1. This corner has been cleared of protruding metal. Attached photo.<br>2. Regular checks of hazardous conditions will be done weekly on weekends by the worker on swing shift.<br>3. The administrator will review the report and follow up any maintenance required. | 06/15/2022 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| 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.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure the courtyard and the hallways in the facility were free of tripping hazards and a courtyard was free from debris. Findings include: On 05/03/22 at 9:00 AM, the courtyard outside Hall A and B contained a concrete walkway with an uneven joint. On 05/03/22 at 9:00 AM, the Caregiver confirmed the concrete was uneven and could be a tripping hazard. On 05/03/22 at 8:56 AM, the flooring in the B Hallway and Room 11-12 had approximately ½ inch cracks between the slats. On 05/03/22 at 8:56 AM, the Caregiver verbalized not knowing why the flooring was like that and confirmed it could be a tripping hazard. On 05/03/22 at 9:07 AM, the courtyard behind the kitchen contained a bed headboard, empty boxes, a cart, a mop, and trashcans. On 05/03/22 at 9:07 AM, the Caregiver verbalized the courtyard was not intended for resident use. On 05/03/22 at 9:44 AM, the Caregiver verbalized residents "could technically" access the courtyard, as the door was kept unlocked. Severity: 2 Scope: 3 | 0178 | 1. Re: uneven concrete on an area not used for clients. Entry to this area is only for workers. A divider was rearranged to separate the area from the residents. Meanwhile, a handyman is looking into resurfacing the concrete - made uneven due to the roots from an old tree on the side.<br>Re: floor crack - these are not cracks but separation of the wood floors and is attributed to "poor installation by Lowes." the floor is only 2 years old and this separation is visible. Lowes do not want to redo the floor without additional costs. The entire floor for Wings A & B costs over $10,000. The openings are not trip hazard because the floor is even. I will talk to a handy man if there is anything that can be done. Meanwhile one possible solution is to install a carpet runner over it. this is under consideration.<br>2. I will consult a handy man to recommend what we can do to improve the yard.<br>3 .Administrator is in charge. estimated meeting with a handyman by 7/31, thereafter a plan will be contracted.<br><br>Note: The patio walking surface is leveled up and debris around were cleared; making it a better area for residents to walk or stroll. A plan to provide a better landscape to this area will be done shortly. To date, the place is cleared of uneven surface for walking. | 07/31/2022 |
| 0179 SS= D | Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. | 0179 | Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI15. | 05/03/2022 |

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 |
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| | | A. BUILDING _____ B. WING _____ | **05/03/2022** |

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| 0272 SS= C | Service of Food - Menus - NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days.<br><br>Inspector Comments: Based on observation, interview, and document review the facility failed to ensure a dated menu was posted. Findings include: On 05/03/22 at 9:08 AM, a resident seated in the dining room verbalized the facility did not post a weekly menu. On 05/03/22 at 9:11 AM, a Caregiver working in the kitchen verbalized the Caregiver wrote the next meal for the day on the white board outside of the kitchen entrance. The Caregiver confirmed there was not a weekly menu posted. On 05/03/22 at 9:15 AM, a Caregiver verbalized there was only a weekly menu located in the kitchen and was not visible to residents for review. The Caregiver provided the food menu. The food menu lacked dates to identify what was being served per day. The Caregiver explained the menus were not dated because the menus were recycled every few weeks. The Caregiver confirmed the menu was not accessible to residents and did not provide the dates of which the food was to be served. On 05/03/22 at 10:16 AM, the Facility Supervisor confirmed the facility did not have a weekly menu posted and the menu should have been posted. Severity: 1 Scope: 3 Complaint #NV00066129 Complaint #NV00065371 | 0272 | 1. Menu are now posted outside the kitchen, weekly plan included. We will keep a planned menu in advance, dated and will be posted. this will be kept on file for 90 days.<br>The Administrator is in charge of this.<br>Overall documentation and posting and working with cook to ensure compliance will be completed by 7/15. | 07/15/2022 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| 0335 SS= D | Bedroom - Certain areas as bedroom prohibited - NAC 449.221 Use of certain areas in facility as bedroom prohibited. (NRS 449.0302) A hall, stairway, unfinished attic, garage, storage area or shed or other similar area of a residential facility must not be used as a bedroom. Any other room must not be used as a bedroom if it: 1. Can only be reached by passing through a bedroom occupied by another resident; or 2. Is used for any other purpose.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure a resident's room was not used for storage of five mattresses in Room 11-12. Findings include: On 05/03/22 at 9:14 AM, Room 11-12 (double occupancy) was occupied by a resident in the section of the room nearest the doorway. A wall partially separated the occupied portion of the room from the unoccupied portion of the room. The unoccupied portion of the room contained five mattresses leaning against walls. On 05/03/22 at 9:14 AM, the Caregiver confirmed an occupied resident room was being used for storage of five matresses. Severity: 2 Scope: 1 | 0335 | 1. The bedroom in question was vacated during the last week of May. The beds were left for pick up by the family. All beds are now removed and the bed is clear and ready for occupancy.<br>2. no bedroom will used for storing extra beds.<br>Administrator and supervisor is in charge of this. | 06/13/2022 |
| 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. | 0450 | Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI15. | 05/03/2022 |

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 |
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| 0515 SS= D | Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; | 0515 | 1. A care plan for each resident will be reviewed as often as necessary.<br>2. This care plan will be reviewed with the staff each time the plan changes.<br>3. Daily, in practice, the turnover each shift include a review of the needs of the residents.<br>4. The Supervisor reviews the shift to shift record and assessment.<br>5. the Administrator reviews all records as often as needed. | 06/15/2022 |
| 0593 SS= F | 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;<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure visitors to the facility were screened for temperature and signs and symptoms of COVID-19 (COVID) and masks were worn by employees and visitors. This lack of Infection Control core principles related to COVID had the potential to affect the resident census of 28 residents. Findings include: On 05/03/22 at 8:30 AM, upon entry to the facility, the six State Surveyors were not screened for temperature and signs and symptoms of COVID and all Caregivers, Medication Technicians and the Cook were not wearing masks. On 05/03/22 at 8:50 AM, the Medication Technician (Med Tech) verbalized the Med Tech was in charge (designee) when the Administrator was absent from the facility. The Med Tech could not produce the facility's Infection Control policy. On 05/03/22 at 9:08 AM, the Supervisor confirmed the six State Surveyors should have been screened for temperature and signs and symptoms of COVID-19 upon entrance to the facility. On 05/03/22 at 9:08 AM, the Supervisor verbalized mask wearing by employees was | 0593 | 1. We have reinstated all Procedures previously prepared and conducted for infection control (COVID19). These include: use of masks, taking of temperatures of all visitors and keep a record.<br>2. We reposted all signs and followed all instructions.<br>3. Temperature is taken as the guest come in and sign in for entry.<br>4. The Med Tech takes the temperature and determines conditions of guests.<br>5. Implementation: 5/15 | 05/15/2022 |

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| | put on hold by the Governor's order. On 05/03/22 at 9:40 AM, the Supervisor verbalized the facility stopped taking resident temperatures and monitoring for signs and symptoms of COVID approximately two months ago. The Supervisor verbalized the Administrator removed all the signs from the building at the entrance directing visitors to wear masks and not enter if sick at the time of the Governor's order masks were not required to be worn. The Infection Prevention and Control Plan for Residential Facilities Coronavirus Disease 2019 (COVID-19) Response Best Practices dated September 20, 2021, and distributed by the State of Nevada Bureau of Health Care Quality and Compliance to all Residential Facilities for Groups on 10/12/21, documented designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms of COVID-19 before starting each shift/when they enter the building. Complaint #NV00065920 On 05/03/22 at 8:30 AM, a Med Tech was in the medication room and was not wearing a mask. The Med Tech verbalized staff were supposed to be wearing masks, however they chose not to wear a mask in the medication room. The Med Tech confirmed not currently wearing a mask in the facility. On 05/03/22 at 8:33 AM, Caregiver #1 was in the kitchen without wearing a mask. The Caregiver verbalized not being fully aware if staff were to wear a mask in the facility. The Caregiver confirmed they were not wearing a mask while prepping and serving food to residents. On 05/03/22 at 8:35 AM, a Caregiver #2 was assisting a resident to the dining room and was not wearing a mask. The Caregiver confirmed they were not wearing a mask and verbalized all staff were required to wear a mask in the facility at all times. On 05/03/22 at 8:36 AM, a Housekeeper was cleaning floors down a hallway and was not wearing a mask. The | | | |

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| | Housekeeper confirmed they were not wearing a mask and verbalized the Housekeeper kept a mask in their pocket at all times. The Housekeeper approached the Supervisor in charge and asked for a mask because the Housekeeper did not have a mask. On 05/03/22 at 10:58 AM, the Supervisor verbalized the Governor had gotten rid of mask mandates so the facility was not requiring staff to wear masks in the facility. The Supervisor confirmed staff were not wearing masks. The Centers for Disease Control and Prevention (CDC) guidance indicated in the "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated February 2, 2022, documented this guidance was applicable to all U.S. settings where healthcare was delivered (including home health). Source control referred to use of respirators or well-fitting facemasks or cloth masks to cover a person ' s mouth and nose to prevent spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. Source control was recommended for everyone in a healthcare setting. Complaint #NV00066129 Complaint #NV00065138 Severity: 2 Scope: 3 | | | |

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 |
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| | | A. BUILDING _____ B. WING _____ | **05/03/2022** |

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| **EAGLE VALLEY CARE CENTRE** | **1807 E LONG STREET, CARSON CITY, NEVADA ,89701** |

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| 0595 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: (f) Residents are allowed to make their own decisions whenever possible;<br><br>Inspector Comments: Based on observation and interview, the facility failed to honor a resident's choice to be transported to the emergency department by ambulance following a fall with injury for 1 of 11 sampled residents (Resident #1) Resident #1 Resident #1 was admitted to the facility on 03/11/22, with a diagnosis of chronic obstructive pulmonary disease. On 05/03/22 at 9:38 AM, a Caregiver verbalized Resident #1 had fallen on 04/20/22. The facility had called hospice and hospice arranged for the resident to be sent to the hospital. On 05/03/22 at 9:40 AM, Resident #1 verbalized the resident had fallen and injured the resident's wrist on 04/20/22. The resident had wanted to be taken to the hospital via ambulance due to severe pain in the resident's wrist after the fall. The facility had refused to send the resident to the hospital because the resident was on hospice. The resident had to wait until the resident's spouse was able to find someone to pick the resident up from the facility and take the resident to the hospital. On 05/03/22 at 9:47 AM, the Facility Supervisor verbalized the resident had fallen and the facility had called hospice. The resident had requested for the facility to call for an ambulance to transport the resident to the hospital, but the facility did not call emergency services because the hospice nurse told the facility the resident was not able to transport via ambulance due to being on hospice and had to wait until a friend or family member was available to take the resident to the hospital. Severity: 2 Scope:1 Complaint #NV00066191 | 0595 | 1. The facility honored the request of the Hospice client to go to the hospital in this instance, by doing the following<br><br>a) immediately called hospice and informed of client's desire to go to ER. WE prepared all docs ready for emergency transport.<br>b) Hospice advised not to ER but to send to an Urgent Care for their manager won't pay for the paramedics. In fact, the Administrator responded to the nurse by objecting bringing the patient to an urgent care instead of the ER><br>c) Facility disagreed and commented that the Urgent Care can not do much for this situation (fall) for they do not have any xray. Hospice responded that they will not pay for the Paramedic transportation.<br>d) Facility suggested to use a nonemergency ambulance. Meanwhile, a family friend was called to take the client to the hospital.<br><br>In the end, this client with low-pain threshold, seen daily by the nurse, constantly calling for pain medications, was brought in and out of the ER for their was no fracture from the fall. A brace was provided to keep the wrist immobile until pain subsides.<br>2. A review of the incident was conducted so the staff can take actions on : requests by residents for emergency care when the client is on hospice care.<br>3. The Supervisor and the Administrator will respond and act to any request for medical care by all resident even for hospice clients.<br><br>NOTE: uploaded plan as requested in email 6/28/2022. | 06/07/2022 |

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| 0620 SS= D | Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis.<br><br>Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to obtain an exemption waiver to allow a resident to remain at the facility while receiving wound care for 1 of 12 sampled residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 11/17/16, with diagnoses including hypotension and a gluteal wound. On 05/03/22 at 9:40 AM, Resident #11 verbalized they had a wound on their bottom and the facility staff were providing care for it. Resident #11's physician order dated 04/25/22, documented a diagnosis of an uncomplicated open wound of the buttock. On 05/03/22 at 11:30 AM, the Administrator verbalized the resident had a wound, the facility had not applied for an exemption waiver to continue providing care to a resident with a wound and did not know an exemption waiver was needed for a resident with a wound to remain in the facility. The Administrator confirmed home health services had not been ordered by the physician to perform wound care. Severity: 2 Scope: 1 | 0620 | 1. The Administrator reviewed the requirements to retain a client with a wound which does not require medical treatment on a 24 hour-basis. This client with a wound did not meet the need for a 24 hour-supervision so an exemption was not filed.<br><br>For the record: this client who has been in the facility since 2016 was not admitted with "gluteal wound" per the citation. This client is seen by the visiting doctor every other week and has just developed an open wound which did not need any other treatment but the use of calmoseptin ointment. The doctor prescribed the use of calmoseptine and the error was in the entry in the MARS - as needed versus doctor's order of 3x daily. The correction on the MARS was made and the doctor's order followed.<br><br>2. Nonroutine doctor's order needs a close review by the supervisor. Routine MARS are prepared and issued by the Pharmacy. Nonroutine are entered manually by the Med Tech. This entry will be closely followed up by the supervisor.<br>3. implementation- asap by 6/8/2022<br>The Supervisor is in charge of reviewing the MARS daily.<br><br>NOTE: uploaded documentation requested 6/28/2022 | 06/15/2022 |
| 0850 SS= D | Medical Care of Resident After Illness - NAC 449.274 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) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' | 0850 | 1. This is a situation where the facility followed all standing agreements between the Hospice Agency and the facility. The facility did per agreement: in any emergency, call the hospice nurse and family - immediately. The specific case is about a client with a very low pain threshold. The nurse visits her almost daily | 07/31/2022 |

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| | s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary.<br><br>Inspector Comments: Based on observation and interview, the facility failed to address a resident's request for medical services in a timely manner when the resident complained of severe pain and requested transport by ambulance to an emergency department for 1 of 11 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/11/22, with a diagnosis of chronic obstructive pulmonary disease. On 05/03/22 at 9:38 AM, a Caregiver verbalized Resident #1 had fallen on 04/20/22. The facility had called hospice and hospice arranged for the resident to be sent to the hospital. On 05/03/22 at 9:40 AM, Resident #1 had a brace for the resident's wrist and verbalized the resident had fallen and injured the resident's wrist on 04/20/22. The resident had wanted to be taken to the hospital via ambulance due to severe pain in the resident's wrist after the fall. The facility had refused to send the resident to the hospital because the resident was on hospice. The resident had to wait until the resident's spouse was able to find someone to pick the resident up from the facility and take the resident to the hospital. On 05/03/22 at 9:47 AM, the Facility Supervisor verbalized the resident had fallen and the facility had called hospice. The resident had requested for the facility to call for an ambulance to transport the resident to the hospital, but the facility did not call emergency services because the hospice nurse told the facility the resident was not able to transport via ambulance due to being on hospice. The resident had to wait until a friend or family member was | | and adjusts the pain medications as needed.<br><br>When she had her fall, we immediately called the hospice and the family. We informed the hospice that the client wants to go to the hospital. The nurse asked us if we have means of transportation to bring her to the nearest Urgent Care because their manager will not pay for the paramedic. I, Daisy commented as to why to an Urgent Care. I, Daisy, the Administrator, who spoke to the nurse, suggested that we call the non-emergency ambulance. Meantime, the family sent their friend to pick her up and she was brought to the ER. She came back with no fracture at all; just tenderness on the wrist and was given a brace to keep the wrist immobile.<br><br>All of the above actions happened without any delay. I am surprised why we are cited for this situation.<br><br>2. I will obtain a written instruction from the Hospice Agency regarding situations where the client wants to go to the hospital despite their advice otherwise.<br>3. The Administrator will handle this. Meet with hospice representatives and discuss this issue. By end of July, I will document all discussions and place on file for the staff to follow.<br><br>NOTE: uploaded documentation per email 6/28/2022 | |

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| | available to take the resident to the hospital. On 05/03/22 at 10:12 AM, the hospice Registered Nurse Case Manager (RNCM) for Resident #1 verbalized, on 04/20/22, the facility had called the hospice agency to notify the hospice the resident had fallen. The RNCM instructed the facility not to call emergency services because the hospice would not pay for ambulance transport. The resident wanted to have the resident's wrist x-rayed due to pain and worried the wrist was fractured. After approximately one and a half hours, the resident's spouse informed the hospice RNCM the spouse had found a friend to pick the resident up from the facility and transport the resident to the hospital. Complaint #NV00066191 Severity: 2 Scope: 1 | | | |
| 0878 SS= D | Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained | 0878 | 1. For new orders, nonroutine, follow up manual entry in the MARS. Monthly MARS for routine meds are prepared by the Pharmacy. Review new orders and entry on MARS to ensure implementation of doctor's order.<br>2. The night shift med tech is now reviewing the MARS as a double check to catch any discrepancy.<br>3. The supervisor will review any findings from the night shift and make correction as needed.<br>4. The Administrator will review records as needed. | 06/15/2022 |

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| | pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.<br><br>Inspector Comments: Based on observation, interview, and clinical document review the facility failed to ensure a medication prescribed by a physician was administered as prescribed for 1 of 12 sampled residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 11/17/16, with diagnoses including hypotension and a gluteal wound. Resident #11's physician order documented Calmoseptine menthol-zinc oxide 44-20 6% ointment apply one application topically three times a day and as needed with toileting to the coccyx. Resident #11's medication administration record (MAR) dated May 1 - May 31, 2022, documented Calmoseptine ointment apply a thin layer to open area on coccyx three times a day as needed with toileting. On 05/03/22 at 10:20 AM, the Administrator confirmed the physician order documented the medication was to be applied routinely three times a day, as needed with toileting, only the as needed administration was on the MAR, and the medication had not been applied routinely three times a day. Severity: 2 Scope: 1 | | | |
| 0895 SS= D | Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that | 0895 | 1. Pre initialing of MAR was investigated. All Med Tech attended a group meeting for this purpose. Every one was reminded that they will initial only after each administration of a pill. | 06/13/2022 |

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| | 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; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician.<br><br>Inspector Comments: Based on observation, interview, and record review the facility failed to ensure the Medication Administration Record (MAR) contained accurate documentation for 1 of 12 sampled residents (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on 11/14/20, and discharged on 12/04/21, with diagnoses including shortness of breath, oxygen desaturation and hypertension. Resident #12's Discharge Summary dated 12/04/21, documented the resident had passed away at 11:00 AM. The MAR for Resident #12, dated December 2021, documented the following medications were administered to the resident after the time of death. -Clonazepam 1 milligram (mg) tablet. Take one tablet by mouth every evening. The medication was documented as administered on 12/04/21 and 12/05/21 at 8:00 PM. -Duloxetine HCL 30 mg CPEP. Take one capsule by mouth at bedtime at 8:00 PM. The medication was documented as administered on 12/04/21 and 12/05/21. -Ferrous Sulfate Elixir 220 mg/5 milliliter (ml) Take 6.82 ml by mouth twice daily for iron deficiency and anemia at 8:00 AM and 5:00 PM. The medication was documented as administered on 12/04/21. -Ferrous Sulfate 325 mg tablet. Take one tablet by mouth twice daily at 8:00 AM and 5:00PM. The medication was documented as administered on 12/04/21. -Gabapentin 100 | | 2. New program: Daily, have the Night Shift (10 pm to 6 am) review the MARs for the day. Results will be reported to the supervisor for action if needed. The night person has the least amount of pills to manage so this task is added to their responsibilities.<br>3. The supervisor will review all reports from the night shift and make necessary actions when needed.<br>4. started 6/15/22 | |

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| | mg capsule. Take one capsule by mouth three times a day as directed for nerve pain at 8:00 AM, 12:00 PM and 5:00 PM. The medication was documented as administered on 12/04/21. -Melatonin 5 mg tablet. Take one tablet by mouth at bedtime for insomnia at 8:00 PM. The medication was documented as administered on 12/04/21. -Morphine Sulfate Extended Release 15 mg. Take one tablet by mouth twice a day as directed for chronic mouth pain at 8:00 AM and 5:00 PM. The medication was documented as administered on 12/04/21. On 05/03/22 at 10:58 AM, the Supervisor explained Resident #12 passed away on 12/04/21 at 11:00 AM and it would not be possible to administer medications to the resident after passing away. The Supervisor confirmed the medications were documented by the Medication Technician as being administered to the resident and verbalized the process was to watch a resident take their medication and then document on the MAR, with staff initials, the medication was administered. The Supervisor was unable to explain why the MAR was pre-initialed as administering medications to Resident #12 after the time of death. Severity: 2 Scope: 1 Complaint #NV00066129 | | | |

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| 0920 SS= F | Medication: Storage - NAC 449.2748<br>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.<br><br>Inspector Comments: Based on observation, interview and clinical record review, the facility failed to ensure medications were secured properly resulting in the potential for residents, unauthorized staff and visitors to access medications. Findings include: At 05/03/22 at 8:35 AM, a Med Tech exited the medication room and did not lock the door. The Med Tech walked several feet away and entered another office and was unable to see the medication room door. Two residents were present in the living room with access to the medication room. The medication room contained two unlocked medication carts and two cabinets with medications and supplies. At 05/03/22 at 8:37 AM, the Med Tech verbalized the Med Tech was out of line of sight of the unlocked medication room. The Med Tech confirmed the medication room door should have been locked. Severity: 2 Scope: 3 | 0920 | 1. A meeting was held with the Med Technician to discuss the need to lock the Med Room all the time. In this instance, the Med Tech left the Med Room to make a copy from the main office; momentarily losing the line of sight of the Med Room.<br>2. Place a copy machine at the Med Room.<br>3. Random monitoring during the day by the supervisor to ensure that the Med Room is not left open for any reason.<br>Supervisor is in charge of this task for compliance. | 06/16/2022 |

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| 0936 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.<br><br>Inspector Comments: Based on interview and clinical record review, the facility failed to obtain a tuberculosis (TB) test within five days of admission and complete a second step tuberculosis (TB) test for 1 of 28 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 01/14/22, with a diagnosis of dementia. Resident #1's clinical record documented evidence of a valid one step TB test given on 02/28/22 and read negative on 03/02/22, 45 days after admission. The resident's clinical record lacked documented evidence of a second step TB test. On 05/03/22 at 10:22 AM, the Owner confirmed Resident #1 received a one-step TB test and did not receive a second step. Severity: 2 Scope: 1 | 0936 | 1&2. Effective immediately, new admission requires a TB Blood Quantiferon test instead of a skin TB test.<br>3. This will be self-monitored upon review of initial admission forms submitted prior to admission.<br>4. Admission papers are reviewed by Supervisor or Administrator. | 06/15/2022 |
| 1001 SS= D | Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. | 1001 | Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI15. | 05/03/2022 |