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 _____	**08/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory grading re-survey and complaint investigation, State Licensure survey initiated at your facility on 07/25/22 and completed on 08/10/22. 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 32. There were four complaints investigated at the time of survey. Complaint #NV00066650 with the allegation a resident with an open wound on the head was walking around the facility with the wound exposed and leaking drops of blood and cerebral spinal fluid could not be substantiated, however additional deficiencies were identified (See Tag Y620). The investigation into the allegation included: Observation of the resident in the common areas and in the resident's room. Interviews were conducted with the Manager, two Caregivers, a Medication Technician, and three residents, including the resident of concern. Clinical record review included a History and Physical, a physician's letter documenting appropriate placement in an assisted living facility, a Physician Standard Placement, and Home Health Notes of the resident of concern. Complaint #NV00066396 with the allegation a resident eloped was substantiated (See Tag Y515). Complaint #NV00066413 with the allegation a resident was bedfast and the facility did not have a waiver from the State Agency was substantiated (See Tag Y620). Complaint #NV00066561 with the following allegations could not be substantiated for neglect or abuse due to a lack of evidence. Allegation #1 the facility would not provide water to the resident, and Allegation #2 the facility did not provide	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AFRODESIA LOPOZ Title: Administrator Date: 12/14/2022

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	Activities of Daily Living (ADL) to the resident. The investigation into the allegation included: Observation of the care provided to residents. Interviews were conducted with the Facility Designee. Review of 10 resident clinical records including the resident of concern. Review of the National Hospice and Palliative Care standards for end of life care. 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 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. 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 Y0053, Y0074, Y0102, Y0104, Y0178, Y0255, Y0272, Y0450, Y0515, Y0593, Y0620, Y0885, Y0895, Y1540, and Y1600. Severity: 2 Scope: 3	0050	I have reviewed and addressed specific citations. Will submit docs upon return to USA, Note: I uploaded docs intended for Tag 053. Responses: 1. I have realigned assignments of staff; ie added a new staff handling Records Review to assist the Day Supervisor. 2. This new assignment staff member reports to Day Supervisor any record to be updated - weekly. 3. Administrator will develop a checklist for the new assignee. 4. The Administrator is responsible for all the tasks to keep the facility in compliance.	10/31/2022

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0053 SS= E	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on attempted personnel record review and interview, the Administrator failed to ensure personnel files were complete for 3 of 12 sampled employees (Employee #6, #11 and #12). Findings include: Employee #6 Employee #6 was hired as a Caregiver with a statrt date of 07/21/22. Employee #6 lacked a personnel record with evidence of elder abuse prevention training, a pre-employment physical exam, and two-step tuberculosis (TB) testing. Employee #11 Employee #11 was hired as a Housekeeper with a start date of 05/10/22. Employee #11 lacked a personnel record with evidence of elder abuse prevention training, a pre-employment physical exam, and two-step TB testing. Employee #12 Employee #12 was hired as a Cook with a start date of 07/01/22. Employee #12 lacked a personnel record with evidence of elder abuse prevention training, a pre-employment physical exam, and two step tuberculosis (TB) testing. On 07/25/22 at 11:25 AM, the Supervisor confirmed the aforementioned employees lacked a personnel file with documented evidence of elder abuse prevention training, a pre-employment physical exam, and two-step TB testing in the facility. Severity: 2 Scope: 2	0053	1. I have corrected the specific findings. Can not upload docs outside the country; will upload when back the USA. 2. Assign a staff member (N. Rausch) for records checks (in addition to my day supervisor). 3. She reports to the supervisor any incomplete file for correction or completion. 4.Special Assign: Recordkeeper 5. 10/31/2022	10/31/2022

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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.	0065	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for	0074	1. All Elder Abuse training has been given to all current employees.)uploading of docs not possible where i am outside USA. 2. Appointed new staff member for records only, A new assigned staff for Records Review has been added. Weekly, does a record review, reports to the Day Supervisor and all records are corrected if not noted as reviewed. Frequency: weekly Day Supervisor is responsible.	10/31/2022

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	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 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			

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	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 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. Inspector Comments: Based on attempted personnel record review and interview, the facility failed to ensure 3 of 12 sampled employees had initial or annual elder abuse prevention training (Employee #6, #11 and #12). 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." Employee #6 Employee #6 was hired as a Caregiver with a start date of			

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	07/01/22. Employee #6 lacked a personnel record and lacked documentation of completing the elder abuse prevention training prior to being scheduled to work in the facility with residents. Employee #6 had been working with resident in the month of July since being hired. Employee #11 Employee #11 was hired as a Housekeeper with a start date of 05/10/22. Employee #11 lacked a personnel record and lacked documentation of completing the elder abuse prevention training prior to being scheduled to work in the facility with residents. Employee #11 had been working with resident in the month of May through July since being hired. Employee #12 Employee #12 was hired as a Cook with a start date of 07/21/22. Employee #12 lacked a personnel record and lacked documentation of completing the elder abuse prevention training prior to being scheduled to work in the facility with residents. Employee #12 had been working with resident in the month of July since being hired. On 07/25/22 at 11:25 AM, the Supervisor was unable to locate elder abuse training in the Employee #6, #11 and #12 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: 2			

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0102 SS= E	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 personnel record review and interview, the facility failed to ensure a tuberculosis (TB) screening was completed for 3 of 12 sampled employees (Employee #6, #11 and #12), and pre-employment physicals examinations were completed for 3 of 12 sampled employees (Employee #6, #11 and #12). Findings include: Employee #6 Employee #6 was hired as a Caregiver with a start date of 07/21/22. The facility lacked an personnel record for Employee #6 to include completed TB screening and a completed pre-employment physical. Employee #11 Employee #11 was hired as a Housekeeper with a start date of 05/10/22. The facility lacked an personnel record for Employee #11 to include completed TB screening and a completed pre-employment physical. Employee #12 Employee #12 was hired as a Cook with a start date of 07/01/22. The facility lacked an personnel record for Employee #12 to include completed TB screening and a completed pre-employment physical. On 07/25/22 at 11:25 AM, the Supervisor confirmed the facility did not have a personnel record, a completed TB screening and a pre-employment physical examination for Employee #6, #11 and #12. The Supervisor confirmed Employee #6, #11, and #12 had been working with residents since each of the employees' hire dates. Severity: 2 Scope: 2	0102	All records on TB screenings have been corrected. Can not upload docs at this location outside USA. Change of Staff Assignments: A new assigned staff for Records Review has been added. Weekly, does a record review, reports to the Day Supervisor and all records are corrected if not noted as reviewed. Frequency: weekly Day Supervisor is responsible.	10/31/2022

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on attempted personnel record review and interview, the facility failed to ensure 2 of 12 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #11 and #12). Findings include: Employee #11 Employee #11 was hired as a Housekeeper with a start date of 05/10/22. The employee lacked a personnel file with documented evidence of fingerprints being submitted, a written criminal history statement, and evidence of a Nevada Automated Background Check System (NABS) Clearance Letter. Employee #12 Employee #12 was hired as a Cook with a start date of 07/01/22. The employee lacked a personnel file with documented evidence of fingerprints being submitted, a written criminal history statement, and evidence of a Nevada Automated Background Check System (NABS) Clearance Letter. On 07/20/22 at 3:22 PM, the facility's NABS account lacked documented evidence Employee #11 and #12 had been entered and cleared in the facility's account. On 07/25/22 at 11:25 AM, the Supervisor confirmed the facility did not have fingerprints, a written criminal history statement, and a NABS Clearance Letter for Employees #11 and #12. Severity: 2 Scope: 1	0104	I sent my employees to the Sheriff's office but was requested to complete a form which i can't find online. I emailed mr. Stout but need to follow up when i am back. New Assignment: A new assigned staff for Records Review has been added. Weekly, does a record review, reports to the Day Supervisor and all records are corrected if not noted as reviewed. Frequency: weekly Day Supervisor is responsible.	10/31/2022

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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;	0106	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022
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.	0174	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022
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. Inspector Comments: Based on observation and interview, the facility failed to ensure environment in the courtyards were free from debris and hazards, the roof on the building was in good condition, resident blinds were in each window and without breaks in the slats and the flooring in the facility was in good repair. Findings include: Courtyards On 07/25/22 at 9:20 AM, the east courtyard had the following items on the patio: -Headboard to a bed -One dolly and one push dolly -Four trash cans -A wooden chair with torn cloth on the seat -A mop bucket -Three egg crates containing trash -A half bed rail -A wooden plank with screws protruding -Metal sheathing -A chemical sprayer for weed control -One tree stand -One walker -Four large bags of trash -Three paint buckets with paint in them. The Designee confirmed the items in the courtyard and verbalized residents did not	0178	I have a regular contractor to do maintennce. I have addressed items of concern. I now have a regular contractor who does repair as needed. See attached invoices/receipts. Cleanup of Yard and Patio: This is now routinely maintained by D.B. Any repairs to be reported to the contractor (George of Desert Pine) & the Administrator supervises completion. Maintenance of Room-Blinds: This has been done routinely each time a room is vacant. Damage to the blinds and/or replacement has always been done each time a room is vacant to prepare the room for new client. However, the case of damaged blinds noted during the last inspection was in rooms occupied by clients for a year or more. We just made a thorough survey of all blinds and replaced where needed - facility wide. see invoices. Person Responsible: Cleanup- Housekeeper and Night Staff to check/audit repair needs & report to Day Supervisor. Day Supervisor contacts Contractor for repair as needed.	10/31/2022

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	use this courtyard much, however, the door always remained unlocked. The Designee explained if a resident were to use the courtyard, the resident could be injured and was not safe to be in the courtyard. On 07/25/22 at 9:26 AM, the west courtyard had the following items on the patio: -A hole in the concrete approximately two feet in diameter and approximately one foot deep. The Designee confirmed the large hole in the concrete and verbalized not knowing the hole was there. The Designee verbalized the patio was for residents to smoke and the residents would visit the courtyard daily. The Designee explained if a resident were to trip or fall into the hole in the concrete, the residents would more than likely break a bone. On 07/25/22 at 9:28 AM, the south courtyard had the following items on the patio: -A large trash bag with trash inside of the bag. -A chair. -A box with a toilet in it. -A half side rail to a resident bed. -Two walkers. -A quarter side rail to a resident bed. -One can of spray paint. -One bike. -One half of a bike. -Two Paint buckets. -The shed in the courtyard contained bed frames, tables, portable commodes, chairs, walkers, side rails and trash. On 07/25/22 at 9:32 AM, the Designee verbalized residents came out to walk on the patio daily. The Designee confirmed all of the items on the patio and in the storage shed were a safety and health hazard to all of the residents. On 07/25/22 at 9:54 AM, there were shingles missing from the roof of the facility, exposing particle board. On 07/25/22 at 9:54 AM, the Designee confirmed shingles were missing from the roof and verbalized the missing shingles could cause damage to the building and resident rooms. The Designee could not verbalize how long the shingles had been missing from the roof. On 07/25/22 at 10:04 AM, there were resident windows, observed from the outside of the building, missing slats in the blinds and broken. On 07/25/22 at 10:04 AM, the Designee confirmed the three		One item that is left open is the Floor separation; Attempts to seal separation with several means (glued cut pieces etc did not work properly). I am looking into a carpet runner for the area. This is expected to be delivered by end of Nov. (This clearance-alleged to be a trip hazard per inspectors has not caused any incident to date. This gradual separation of the newly installed floor (2 yrs old) was a construction defect by Lowes.)	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
	resident rooms had broken and missing blind slats. On 08/10/22 at 10:45 AM, observations of the flooring in the A Wing and the B Wing showed the flooring contained separation between the flooring pieces of approximately 1/4 to 1/2 inches and the flooring was bowed up in some locations. On 08/10/22 at 11:58 AM, the Medication Technician verbalized a worker had been in the facility to assess the condition of the floors in both Wings but no work had been initiated. 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 on 7/25/22, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446 at the time of inspection. Findings include: 1. Critical Violations: a. Raw eggs were stored on a counter-top next to the cooking range. The temperature of the raw eggs were at 72 degrees F. b. Cooked oatmeal was hot holding in a pot at 120 degrees F. on the cooking range. c. Raw meat was stored over orange juice containers on the walk-in refrigerator shelves. d. Multiple employees were observed entering the kitchen area, including the walk-in refrigerator, without washing their hands. e. The high temperature dishwashing machine was not reaching the required final rinse temperature. The final rinse temperature was observed at 165 degrees F. 2. Major Violations: a. Multiple food items in the walk-in refrigerator, stored in containers and bags, were not properly dated and identified. b. Potentially hazardous foods, hot dogs, raw chicken, and a sauce packet,	0255	Responses: I have hired a new cook. After a month, he will be taking a ServSafe training. 1) Food Storage - this has been reviewed and discussed with staff during their monthly meeting in October. The new cook is implementing the guides for compliance. Labeling and placing a date on all stored food was also a topic during the training. 2) Dishwasher - I spoke with the Repair Man regarding the temperature - not hot enough. Since they have seen this equipment for years (since 2003) and have made repairs in various parts including temperature control, they told me to consider buying a new one. We discussed the cost and they will provide me a proposal for replacement. Target date for replacement- end of Dec. (canvas, order with longer weeks turnaround) 3) Sanitizing in the kitchen - this is currently done and training the employees to ensure that they wash hands before entering the kitchen area and the walk -in refrigerator is being done. 4) Leaks - all leaks around the sink area has been repaired. Responsible Person: Cook/Day Supervisor monitoring The Administrator is responsible in compliance.	12/14/2022

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	were thawing on the kitchen counter-top. c. There was no sanitizer solution to properly store wet wiping cloths. Kitchen wet wiping cloths were not stored in a sanitizer solution. d. The cooking range grease and food debris pan, located under the stove burners, was excessively dirty with food debris and grease drippings. e. A single service cottage cheese plastic container was re-used to store resident food. f. The dishwashing machine was leaking water onto the kitchen floor during operation. g. There was no handwashing soap at the kitchen handsink. Severity: 2 Scope: 3			
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. Inspector Comments: Based on observation, interview, and document review the facility failed to ensure a dated menu was posted. Findings include: On 07/25/22 at 9:07 AM, located at the doorway leading to the kitchen, was a weekly menu posted on the wall. The weekly menu was undated. The facility also lacked evidence the food menu was filed for the last 90 days. On 07/25/22 at 9:40 AM, the Designee confirmed the weekly menu was undated and the facility did not keep 90 days of the food menu. Severity: 1 Scope: 3	0272	We have menus in writing. Note: with our new cook, we are documenting the meals served if different from the suggested menu. Responses: 1) we have prepared menu in writing for six week cycle; in the past, this has not been dated but followed unless a substitution was made. As of the week of /Nov 7, we are changing the procedure: A weekly menu starting the week of November 7 will be dated, followed or substituted as documented by cook. 2) Weekly this menu is posted with date - and any substitution will be documented and also written on the Board for the day's info. 3) Daily - this will be monitored by the cook 4) At the end of each week, the menu sheet and the substitution will be kept on file for the next 90 days. 5) Recordkeeping to be check by Staff; file updated. The Day Supervisor works with the cook to ensure the records are complete at the end of the week.	10/31/2022

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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.	0335	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022

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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 personnel record review and interview, the facility failed to ensure 2 of 9 sampled employees maintained training and certification to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #1 and #8). Findings include: Employee #1 Employee #1 was hired as a Medication Technician with a start date of 09/20/10. Employee #1's personnel file documented cardiopulmonary resuscitation (CPR) training dated 06/17/20 and expired 06/30/22. The personnel file lacked documented evidence of current CPR and first aid certification. On 07/25/22 at 11:27 AM, the Supervisor confirmed Employee #1 lacked current CPR and first aid training. Employee #8 Employee #8 was hired as a Medication Technician with a start date of 08/19/19. Employee #8's personnel file documented CPR training dated 08/19/19 and 06/07/22. The CPR and first aid training taken by Employee #8 on 06/07/22 lacked evidence of CPR and first aid skills testing. On 07/25/22 at 11:35 AM, the Supervisor confirmed Employee #8's CPR and first aid training was online only and lacked skills training. Severity: 2 Scope: 1	0450	Staff #8: Quit; she had a online certificate. Staff #1; earlier online certificate to be replaced with an -in person training certificate scheduled on Nov. 16. 1. The newly assigned Record keeper Staff - will check records including the FA/CPR to ensure compliance. 2. This is a new assignment. 3. Personnel files to be reviewed as often as needed, preferably upon start of employment and annually thereafter. 4. Day supervisor to follow up any record noncompliance.	11/16/2022
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	0515	Citation- Elopement of client 1) This incident was reviewed with the staff during the monthly training session. 2) This elopement happened during the night when the night staff turned off the door alarm- since this incident, the night	10/31/2022

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	required supervision; Inspector Comments: Based on record review and interview, the facility failed to provide protective supervision to prevent a resident from eloping for 1 of 12 residents (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on 11/29/21 and discharged on 04/21/22, with diagnoses including dementia, alcoholism and type two diabetes mellitus. Resident #12's clinical file documented an incident report dated 04/02/22, the Owner received a call from the Sheriff's Department. The Owner was notified Resident #12 was found walking outside on the streets. Upon further investigation, it was discovered the resident had walked out of the front doors of the facility. The front doors were alarmed to sound when an individual would come in or out of the facility. The staff had deactivated the alarm to the doors and were not aware the resident had eloped from the facility. The Sheriff's report dated 04/02/22, documented a resident had eloped from the facility and was picked up by law enforcement for further evaluation and investigation. On 07/25/22 at 11:24 AM, a resident sitting in the dining room area verbalized the door alarms were usually deactivated by staff on a nightly basis. On 07/25/22 at 11:36 AM, the Designee verbalized there was an alarm on the front door to notify staff if anyone came in and out of the facility and the door alarm was supposed to be active at all times. The Designee explained Resident #12 had eloped from the facility and an unknown individual had called the police to investigate. The resident was brought back to the facility. The Designee verbalized the resident had a diagnosis of dementia so the expectation would be for staff to supervise the resident at all times to prevent an elopement. The Designee confirmed Resident #12 had eloped from the facility and staff had no idea the resident had		persons were told to keep the door alarms on at all times. 3) All incidents have been documented and night alarms have been activated at all times. This resident was discharged into a lock unit in a different facility.	

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	eloped for an undetermined amount of time. The Designee verbalized the resident could have been hurt as a result from the elopement. The Designee verbalized the resident should have been in a higher level of care and the facility was not appropriate for placement. Complaint #NV00066396 Severity: 2 Scope: 1			
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; 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 being worn by staff members. This lack of Infection Control core principles related to COVID had the potential to affect the resident census of 29 residents. Findings include: On 07/25/22 at 9:00 AM, upon entry to the facility, the five State Surveyors were not screened for temperature and signs and symptoms of COVID and a Medication Technician and the Designee were not wearing masks. On 07/25/22 at 9:06 AM, the Medication Technician and Designee confirmed they were not wearing a mask. The Designee confirmed the five State Surveyors should have been screened for temperature and signs and symptoms of COVID-19 upon entrance to the facility. The facility policy titled, "Current Infection Control Program," undated, documented staff and visitors would be screened with temperatures upon entering the facility to ensure anyone with a fever would not be permitted to enter the building during the pandemic. Severity: 2 Scope: 3	0593	This has been corrected. will explain in detail upon return. Responses: The use of mask at all times, following CDC guidelines was reviewed during the monthly meeting in October. 1. We continue the practice of monitoring the temperatures of guests and the log sheet has all the records. Just a note; during the State visit, the staff did not or failed to monitor the temperature of the 5 State surveyors due to panic or nervousness - knowing that we have an inspection. Otherwise, all visitors have to sign in and have their temperature taken. 2. The Med Tech is in charge of taking the temperature of all visitors. The Med Tech also monitor the temperature of all residents every shift to keep the facility updated on the condition of everyone. Day supervisor is following compliance for this items.	10/31/2022

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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;	0595	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022
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. Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to ensure a bed bound resident and a resident receiving wound care was not admitted or retained for admission to the facility for 2 of 11 sampled residents (Resident #1 and #11). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/18/21, with a diagnosis of Alzheimer's dementia. On 07/25/22 at 10:10 AM, Resident #1 was in bed and was unable to answer questions. The left side of the bed was against the wall and the bed rail on the right side was raised. On 07/25/22 at 10:30 AM, the Facility Designee verbalized the resident could not change positions or get out of bed independently, was bed bound, and the facility had not obtained a bed bound waiver. The facility policy titled "Bedfast Resident", undated, documented if a current resident became bedfast a waiver would be submitted to the state agency. Resident #11 Resident #11 was admitted to the facility on 06/20/22, with a diagnosis of dementia. On 07/25/22 at 9:20 AM, Resident #11 was in	0620	The hospice client passed away before I could submit an exemption for bedfast waiver. 1. In the future, all bedfast client must have a waiver to continue residency in the facility. 2. There is no admission made for a bedfast client. 3) When a resident becomes bedfast, a doctor's approval to continue residency be acquired and these documents will be use to request a waiver to stay. 4. The Supervisor is responsible in identifying the needs and the Administrator will prepare the waiver.	10/31/2022

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	the living room with a bandage on the resident's head. The resident removed the bandage revealing a wound on the left side of the head. On 07/25/22 at 9:25 AM, a Medication Technician verbalized a home health agency nurse provided wound care to Resident #11 every other day. On 07/25/22 at 9:28 AM, the Manager verbalized a home health agency nurse provided wound care to Resident #11. The Manager was not aware if an exemption request had been submitted to the State Agency to admit or retain Resident #11 with the resident's wound. Resident #11's clinical record lacked documented evidence an exemption request was submitted to the State Agency. Severity: 2 Scope: 1			
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 ' 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.	0850	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022

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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 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.	0878	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, clinical document review, and interview the facility failed to ensure a medication was destroyed when the order had expired for 1 of 10 residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 11/22/17, with a diagnosis of periapical abcess. On 07/25/22 at 11:12 AM, an almost empty bottle of Robafen liquid was in the medication cabinet and labeled with Resident #5's name. Resident #5's physician order dated 12/03/21, documented Robafen liquid take 10 milliliters (ml) by mouth every four hours as needed for cough for up to 15 days. On 07/25/22 at 12:15 PM, the Medication Technician verbalized the medication should have been discontinued on the medication administration record 15 days after the order was started and the medication should have been destroyed. Severity: 2 Scope: 1	0885	Reviewed records. MARS: Robafen mucus/chest congestion (Take 10 ml by mouth every 4 hours as needed for cough for up to 15 days) The use of this Robafen was ordered in Dec. 2021 and was administered as ordered. The almost empty bottle found during the State visit was destroyed immediately. Comment on this: the order as written is still in the MARS each month. We have not ordered any since Dec 2021 for the patient does not need it. There has been no record in all MARS sheet since Jan 2022. 1) All medications are administered as ordered. All PRN medications that has not expired and are on the MARS list is kept on storage. All empty bottles should be discarded appropriately. 2) In this case of an almost empty bottle but not expired meds, the Med Tech kept the bottle in storage because the PRN meds is still in the MARS. During the State Visit this has been destroyed accordingly. The MARS has carried this PRN MEds month after month. We only order when needed. No order has been made on this medications since Jan 2022. All MARS record for each month since January 2022 are blank accordingly. Attached the Oct Mars. 3. Meds records are check routinely and daily by the Day Supervisor.	10/31/2022

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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 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. Inspector Comments: Based on observation, interview, and clinical document review the facility failed to ensure an as needed medication had symptoms being treated documented on the medication administration record (MAR) for 1 of 10 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 06/04/21, with a diagnosis of Parkinson's. Resident #10's MAR dated July 1, 2022 - July 31, 2022, documented Omeprazole Capsule 20 milligram (mg) take one capsule by mouth once daily as needed. Resident #10's physician order dated 06/25/21, documented Omeprazole Capsule 20 mg, delayed release, take one capsule by mouth daily as needed for gastric reflux or hyperacidity. On 07/25/22 at 11:45 AM, the Medication Technician verbalized the MAR should have had the symptom being treated on it and the MAR should have matched the physician order. Severity: 2 Scope: 1	0895	Reviewed records. I believe there was a miscommunication between the Med Tech and the Surveyor regarding this PRN Med. Attached are the MARS since July 2021. No record has been found on the use of this for - gas etc. The order was renewed by the physician in July (a year after the initial order). Attached are sample records of PRN use recorded properly for Resident #10 (attached) The recording of PRN meds; i.e. date/time/results have been documented properly. The Day Supervisor will continue to monitor the recordkeeping of PRN meds and all meds.	10/31/2022

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
		A. BUILDING _____ B. WING _____	**08/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.	0920	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022
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.	0936	Please refer to original Statement ofDeficiency/Plan of Correction - Event ID I5TI16.	10/31/2022

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1540 SS= F	Cultural Competency Training Inspector Comments: Based on personnel file review and interview, the facility failed to ensure all employees received cultural competency training within 30 days of their date of hire for 10 of 10 sampled employees. (Employee #1, #2, #3, #4, #5, #7, #8, #9, #10, and #11). Findings include: On 07/25/22 in the morning, a review of personnel files revealed the following employees lacked documented evidence of cultural competency training: - Employee #1 was hired as a Medication Technician (MT) with a start date on 01/01/09. - Employee #2 was hired as a Caregiver (CG) with a start date on 04/28/20. - Employee #3 was hired as CG with a start date of 01/06/21. - Employee #4 was hired as a MT with a start date of 07/20/19. - Employee #5 was hired as a CG with a start date of 06/01/22. - Employee #7 was hired as a MT with a start date of 09/20/10. - Employee #8 was hired as a MT with a start date of 08/19/19. - Employee #9 was hired as a CG with a start date of 07/25/16. - Employee #10 was hired as a Supervisor with a start date of 01/01/05. - Employee #11 was hired as a Housekeeper with a start date of 05/10/22. On 07/25/22 at 11:26 AM, the Supervisor confirmed all employees had not taken an approved cultural competency training course. Severity: 2 Scope: 3	1540	will address training when I am back. I am currently reaching out to vendors - been told that there are 4 and will cost $100 per person to be trained. Will update and comply on or before the end of Dec.	12/31/2022
1600 SS= C	Preferred Name/Pronoun P& P Inspector Comments: Based on interview, the facility failed to develop policies addressing the facility's program for cultural competency. Findings include: The Supervisor confirmed facility policies had not been developed for a cultural competency program for the facility. Severity: 1 Scope: 3	1600	I am currently reaching out to vendors - been told that there are 4 and will cost $100 per person to be trained. Will update and comply on or before the end of Dec. attached Policy on Training for Cultural Competency based on my latest training with a vendor.	12/12/2022