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 _____	**04/13/2023**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory grading re-survey and complaint investigation, State Licensure survey conducted at your facility on 04/13/23. 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 33. Six resident files were reviewed and seven employees files were reviewed. The facility received a grade of D. 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 five complaints investigated at the time of survey. Complaint #NV00067347 with the allegation a resident was physically obstructed by employees to prevent the resident from leaving the facility was substantiated (See Tag #Y0590). Complaint #NV00066967 and #NV00068259 with the allegation the facility was keeping a resident's social security checks after the resident discharged from the facility could not be substantiated due to a lack of evidence. The investigation into the allegation included: Observations included a tour of the facility. Interviews were conducted with the Supervisor and the Administrator. Document review included	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: AFRODESIA LOPOZ Title: Administrator Date: 08/15/2023

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	the admission packet, placement determination, financial dockets, discharge records, email correspondence and a policy on resident rights. Complaint #NV00067566 with the following allegations was investigated: Allegation #1 a bathroom fan in a resident's room was not working causing improper ventilation was substantiated (See Tag #Y0178). Allegation #2 a shower chair was rusted could not be substantiated due to lack of evidence. Allegation #3 employees did not have eight hours of caregiver training in their files could not be substantiated due to lack of evidence. The investigation into the allegations included: Observations included a tour of the facility and shower rooms. Interviews were conducted with two residents, two caregivers, and the Supervisor. Document review included the caregiver employee files. Complaint #NV00067649 with the following allegations could not be substantiated due to lack of evidence: Allegation #1 a resident was receiving meals in disposable containers. Allegation #2 a resident's room was not clean. Allegation #3 a resident had an unexpected death due to neglect. The investigation into the allegation included: Observations included a tour of the facility, resident rooms, residents eating breakfast and lunch in their rooms and the community dining rooms, staff responding to call lights, and call lights at bedsides. Interviews were conducted with two residents, three caregivers, and the Supervisor. Clinical record review included the resident of concern's Activities of Daily Living Assessments, Medication Administration Records, Treatment Administration Records, Medication Destruction Sheets, Serious Incident Report, History and Physical, Annual Physician Placement Determination, Hospital Discharge Summary, Sheriff Office Statement, and facility Incident Report. Document review included facility staffing schedules and employee files. The findings and			

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	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 Y0074, Y0102, Y0104, Y0178, Y0255, Y0272, Y0450, Y0590, Y0620, Y0895, Y0920, Y0923, Y1010, and Y1540. Severity: 2 Scope: 3	0050	The facility will hire a consultant (for a fee) to assist or support us in maintaining compliance. Preliminary discussions were already made with an outside agency to do the tasks described below. The original thought was to hire an Assistant Administrator; to provide a fresh look and follow up of items. However, this idea is NOT economically feasible for a small facility. Tasks for the consultant: 1. Quarterly if not more often as needed, conduct a review, prepare a report and recommendations to maintain compliance. The current system of having a separate personnel assigned for this did not work well. The day supervisor still ended up overseeing the records. This review will be patterned after the current Med Reviews conducted by the Pharmacy every 6 months. These regular reviews result in a cooperative operation between our staff and the Pharmacist; resulting in open communication as to how issues will be addressed. 2. Provide training as needed. 3. Schedule to conduct the first review; August 1, 2023 This is the estimated time for the facility to correct the deficiencies and then request for a review. So for the responses: 1. The above plan will correct the deficiency on the administrative oversight. Meanwhile we will work to complete all required documentation to meet the requirements. 2. The reviews will provide a measurable progress. 3. The external review is a measure of	06/16/2023

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			success. 4. Daisy Lopoz, Administrator is responsible to make this happen. 5. Corrective actions have already started with the training etc. Ex. Training on mental health completed 6/2023 A written contract with the consultant will be provided when available.	
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.	0053	Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI17.	04/13/2023
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or	0074	1. This loss of record for elder abuse is something we are looking into. The caregiver in question had an elder abuse documentation but we can not locate it. She is taking another training with documentation 2. The change of overseeing records through an outsider reviewer will highlight any lack of records or any missing records in the future. 3. The periodic review will provide a measurable extent of progress. 4. The Administrator is responsible to make this happen.	06/13/2023

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	licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care			

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	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 personnel file review and interview, the facility failed to ensure 1 of 7 sampled employees had initial or annual elder abuse prevention training (Employee #4). 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." The facility's POC dated 12/14/22, documented, "the Day Supervisor was responsible to review and ensure all employee records were complete." Employee #4 Employee #4 was hired as a Caregiver/Medication Technician with a start date of 12/15/20. Employee #4's personnel file documented an elder abuse			

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	prevention training dated 01/07/22. Employee #4's personnel file lacked documented evidence of elder abuse prevention training for 2023. On 04/13/23 at 11:20 AM, the Supervisor confirmed Employee #4's personnel file lacked documented evidence of elder abuse prevention training and the certificate of completion was not in another location. Severity: 2 Scope: 1			
0102 SS= F	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 file review and interview, the facility failed to ensure 1) a tuberculosis (TB) screening was completed for 6 of 7 sampled employees (Employee #2, #3, #4, #5, #6 and #7), and 2) a pre-employment physical examination was completed for 5 of 7 sampled employees (Employee #1, #2, #3, #5 and #7). Findings include: The facility's Plan of Correction (POC) dated 12/14/22, documented, "the Day Supervisor was responsible to review and ensure all employee records were complete." Employee #1 Employee #1 was hired as a Caregiver with a start date of 03/01/23. Employee #1's personnel file lacked documented evidence of a completed pre-employment physical. Employee #2 Employee #2 was hired as a Caregiver with a start date of 12/12/22. Employee #2's personnel file documented a one step TB test given on 02/13/23 at 2:36 PM and read negative on 02/16/23 at 12:36 PM. Employee #2's personnel file lacked documented evidence of a second step TB test and a completed pre-employment physical. Employee #3 Employee #3 was hired as a Caregiver with a start date of 01/15/23. Employee #3's personnel file	0102	1 I am reviewing all records for TB screening and health certificates The deficiencies include an employee who already resigned, employees whose TB readings were questioned for time read, and absence of health certification for new employees At the present time, there is a turnover of employees and the records are being reviewed 2 & 3 I need until the end of the month to get all employees' records completed, considering some are resigning and some are being interviewed Future plan of having an outside Auditor/Reviewer (for a fee) is expected to improve compliance Administrator is responsible for all these NOTE: Starting immediately all new employees who need TB tests will be asked to obtain a Quantiferon rather than Skin Test for TB screening. Employees who have been tested and Reading times were in question (48 to 72 hours range) are not planned to obtain Quantiferon Tests Results as of 6/21; #1 staff resigned in April. #2 on leave for family's death (be back on 6/28) will take tests #3 Done #4 done #5 done #6 done #7 done	06/30/2023

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	lacked a completed two-step TB test and a completed pre-employment physical. Employee #4 Employee #4 was hired as a Caregiver/Medication Technician with a start date of 12/15/20. Employee #4's personnel file documented an annual TB test given on 10/08/22 at 9:00 AM and read negative on 10/11/22 at 11:30 AM. The TB test was read beyond the 48 to 72 hours read time, one and one-half hours late. Employee #5 Employee #5 was hired as a Caregiver//Medication Technician with a start date of 09/20/10. Employee #5's personnel file documented an annual TB test given on 10/08/22 at 9:30 AM and read negative on 10/11/22 at 10:15 AM. The TB test was read beyond the 48 to 72 hours read time, forty-five minutes late. Employee #6 Employee #6 was hired as a Caregiver with a start date of 04/13/23. Employee #6's personnel file lacked a completed two-step TB screening and a completed pre-employment physical. Employee #7 Employee #7 was hired as a Cook with a start date of 11/21/22. Employee #7's personnel file lacked a completed two-step TB screening and a completed pre-employment physical. On 04/13/23 at 1:05 PM, the Supervisor confirmed Employee #2, #3, #4, #5, #6 and #7 lacked completed tuberculosis TB testing and Employee #1, #2, #3, #5 and #7 lacked pre-employment physical examinations. The Supervisor verbalized the documents were not in another location. Severity: 2 Scope: 3		Response as of 8/15/23 Employee #3 has been out sick and is not expected to come back to work.	
0104 SS= F	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 personnel file review, document review and interview, the facility failed to ensure 5 of 7 sampled employees met the background check	0104	1. I am reviewing all requirement and working with the employees to comply 2 & 3 routine review of new and over 5 yr - employees The Administrator is responsible for this I am awaiting all fingerprints to be completed and processed I expect all completion by the end of the month Status as of 6/21: 3 completed #2 on leave for death of family will be back	06/30/2023

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	requirements of Nevada Revised Statute (NRS) 449.124 (Employee #2, #3, #5, #6 and #7). Findings include: The facility's Plan of Correction (POC) dated 12/14/22, documented, "the Day Supervisor was responsible to review and ensure employee records were complete." Employee #2 Employee #2 was hired as a Caregiver with a start date of 12/12/22. Employee #2's personnel file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 04/13/23 at 1:07 PM, the Supervisor confirmed Employee #2's personnel file lacked documented evidence of submitted fingerprints, a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #2 was scheduled to work in April 2023. Employee #3 Employee #3 was hired at the facility as a Caregiver with a start date of 01/15/23. Employee #3's personnel file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 04/13/23 at 1:11 PM, the Supervisor confirmed Employee #3's personnel file lacked documented evidence of submitted fingerprints, a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #3 was scheduled to work in April 2023. Employee #5 Employee #5 was hired as a Caregiver/Medication Technician with a start date of 09/20/10. Employee #5's personnel file documented a NABS Clearance letter dated 02/09/17. Employee #5'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, a Criminal History Statement, and a		on 6/28) #3 Done #5 waiting for renewal of driver's license, will be expected week of 6/26 #6 Done #7 Done	

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	NABS clearance letter for the facility. On 04/11/23 at 1:25 PM, NABS documented Employee #5 was listed eligible-expired on the roster for the facility. On 04/13/23 at 1:15 PM, the Supervisor confirmed Employee #5's NABS was expired, had not been renewed and verbalized Employee #5 was scheduled to work in April 2023. Employee #6 Employee #6 was hired as a Caregiver with a start date of 04/13/23. Employee #3's personnel file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History and lacked a Criminal History Statement. On 04/13/23 at 1:05 PM, the Supervisor confirmed Employee #6's personnel file lacked documented evidence of submitted fingerprints, and a Criminal History Statement and verbalized Employee #6 was scheduled to work in April 2023. Employee #7 Employee #7 was hired as a Cook with a start date of 11/21/22. Employee #7's personnel file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 04/13/23 at 1:20 PM, the Supervisor confirmed Employee #7's personnel file lacked documented evidence of submitted fingerprints, a Criminal History Statement and a NABS clearance letter for the facility and verbalized Employee #7 was scheduled to work in April 2023. Severity: 2 Scope: 3			
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	0178	1 We have a maintenance person on call We have been replacing the floor at the dining area and kitchen and repainting the area too, In addition, every time a room is vacated, we renovate the room (floors and painting) and these activity will also end up with debris at the back patios 2 The patio and debris are gone - 3 We cleaned up the garbage area and a swinging gate to keep the garbage out of sight has been planned and installation is	11/15/2023

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	building was in good condition, resident blinds were in each window and without breaks in the slats, the flooring in the facility was in good repair, the heating/air conditioning return vents and filters were free of dust and debris, the patio access door was in good repair, and maintenance was performed. Findings include: Courtyards On 04/13/23 at 9:15 AM, the west courtyard had the following items on the patio: - bed frame - two bike frames locked to the bed frame - one five gallon bucket full of paint - an unlocked storage shed On 04/13/23 at 9:25 AM, the south courtyard had the following items on the patio: - several sheet of Plexiglas - a four leg walker with wheels and seat - a snow removal machine - painting tools and brushes - a bucket - six broken down cardboard boxes - a mop bucket and mop ringer - a dolly - a white cabinet - a plastic bin full of aluminum cans - a ladder - an unlocked storage shed with chemicals On 04/13/23 at 3:17 PM, the north courtyard had the following items on the patio: - a twin size bed mattress On 04/13/23 at 9:25 AM, the Supervisor verbalized residents came out to walk on the patio daily. The Supervisor confirmed all of the items on the patio were a safety and health hazard to all of the residents. On 04/13/23 at 9:50 AM, the Supervisor confirmed all eight heating/air conditioning return vents and filters had a heavy accumulation of lint and dust and verbalized not knowing the last time the vents were cleaned and the air filters changed. On 04/13/23 at 9:30 AM, there were resident windows, observed from the outside of the building, missing slats in the blinds and broken. On 04/13/23 at 9:30 AM, the Supervisor confirmed portions of the flooring in the A Hallway, B Hallway and the A/B Common Room had gaps or were buckling and verbalized they created a hazard for residents. On 04/13/23 at 9:35 AM AM, the Supervisor confirmed the two resident rooms had broken and missing blind slats. On 04/13/23 at 3:20 PM,		expected anytime The Administrator is responsible in following this up Response as of 8/15/23 Repairs for the roof is expected to be completed before winter, Nov. 15, 2023.	

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		A. BUILDING _____ B. WING _____	**04/13/2023**

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	the Supervisor confirmed shingles were missing from the roof and verbalized the missing shingles could cause damage to the building and resident rooms. The Supervisor could not verbalize how long the shingles had been missing from the roof. On 04/13/23 at 3:23 PM, the Supervisor confirmed the patio door was in a state of disrepair and there were screws exposed creating a hazard for residents. Severity: 2 Scope: 3 On 04/13/23 at 9:20 AM, the bathroom ventilation fan in Room B10 did not work. On 04/13/23 at 11:14 AM, the Supervisor confirmed the ventilation fan in room B10 did not work. The Supervisor explained the bathroom fans should be in working order for proper ventilation. The broken ventilation fan had not been reported to maintenance. Severity: 2 Scope: 3 Complaint #NV00067566			
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 4/13/23, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. The high temperature dishmachine was not sanitizing at the time of inspection. Further observation noted the interior machine water dispensing manifolds were damaged and not rotating under pressure. 2. Major Violations: a. The walk-in refrigerator condenser coils and fans were dirty. b. The kitchen's cook's line ventilation hood filters were dirty. c. The floors under and behind the kitchen stove were dirty. Severity: 2 Scope: 2	0255	1 The kitchen area (under and around the stove has been cleaned The condenser coils were cleaned The issue of a dishwasher was discussed in the last report and citation: this is the status to date All staff and cook are aware that the dishwasher temperature is slightly lower that 185F (only 165 to 170F) As a result we use the 3-sink compartment to sanitize the dishes before we put the dishes in the dishwasher to dry 2 & 3 when budget allows I will buy a new dishwasher The priority is still building maintenance 4 Administrator will purchase a new dishwasher within 6 months Administrator is responsible for this tasks	06/12/2023

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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. Inspector Comments: Based on observation, interview, and document review the facility failed to ensure a dated menu was posted and menus were kept on file for 90 days. Findings include: The facility Plan of Correction dated 12/14/22, documented, "the facility would post weekly menus and the Day Supervisor was responsible to ensure their posting." On 04/13/23 at 9:08 AM, a bulletin board located at the doorway to the kitchen for posting menus was missing and the weekly menu was not posted for residents to read. The facility also lacked evidence the food menu was filed for the last 90 days. On 04/13/23 at 9:12 AM, the Supervisor confirmed the weekly menu was not posted in the facility and the facility did not keep the last 90 days of the food menu. Severity: 1 Scope: 3	0272	1 During the visit, the menu sheets at the back of the kitchen door were removed in preparation for the painting of the walls. The bulletin board for the daily menu in the front was also removed to clear the wall for painting. We do have the menu in writing on the new bulletin board (the menu covers 6 weeks for each season) We have a binder maintained by the cook to record what they have served (substitution) 2&3 the daily menu has been posted for the residents to read These are now posted in our new bulletin board after the walls were painted 4 The Administrator is responsible for this	06/12/2023

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0450 SS= E	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 file review and interview, the facility failed to ensure 3 of 7 sampled employees maintained training and certification to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #1, #2 and #3). Findings include: The facility's Plan of Correction dated 12/14/22, documented the Day Supervisor was responsible to review and ensure all employee records were complete. Employee #1 Employee #1 was hired as a Caregiver Technician with a start date of 03/01/23. Employee #1's personnel file lacked documented evidence of current CPR and first aid certification. Employee #2 Employee #2 was hired as a Caregiver Technician with a start date of 12/12/22. Employee #2's personnel file lacked documented evidence of current CPR and first aid certification. Employee #3 Employee #3 was hired as a Caregiver Technician with a start date of 01/15/23. Employee #3's personnel file lacked documented evidence of current CPR and first aid certification. On 04/13/23 at 11:45 AM, the Supervisor confirmed Employee #1, #2, and #3 lacked CPR and first aid training within 30 days of their hire date and verbalized the employees had been scheduled to work with residents since their hire dates. Severity: 2 Scope: 2	0450	1. Obtain employee training and certificate for First Aid and CPR (5/18/23) for active employees #2 nd #3 Employee #1 resigned in April. 2. & 3. Focused review of records and outside audits would help. 4. Administrator 5. This deficiencies have been corrected 5/18/2323	05/18/2023

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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	Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI17.	04/13/2023
0590 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on interview and document review, the facility failed to ensure a resident had the right to leave the facility and not be physically blocked from exit for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/03/20, with diagnoses including type two diabetes mellitus, Parkinson's Disease and unsteady gait. On 04/13/23 at 9:20 AM, Resident #1 explained a while back, the resident would ask to go for a walk or visit friends and the facility would tell the resident no each time. At one point in time, two staff members blocked the front door to prevent the resident from leaving. The resident described feeling trapped inside the facility. On 4/13/23 at 10:50 AM, the Supervisor verbalized if residents were well enough and able to leave, the residents would be able to leave the facility at will. If a resident was in a wheelchair, the resident would need assistance in order to leave the facility, but still could leave at any time. The Supervisor explained Resident #1 was told the resident could not leave the facility multiple times and there was an incident where two staff members had blocked the	0590	1 This case has been investigated and the case closed by the Ombudsman The following circumstances resulted from this incident The resident wanted to visit his friend across the street and was told not to leave alone. He must wait for his friend to pick him up (for safety reasons) I am clarifying where he wanted to go for normally he would be picked up by his friend to go to their apartment This incident happened in the early evening when normally he gets confused and his tremors are worst. The insisted to leave but was told not to by the staff The staff prevailed The discussion on this CLOSED case resulted in the following: Parties involved: Resident, Ombudsman, Friend & Administrator a) The resident may leave alone - per Ombudsman b) the resident should wait for the friend to be picked up - per family c) the resident does not have a POA so the resident can decide for himself per Ombudsman d) The Administrator's position if he is allowed to go next door in his condition; the facility will not take any responsibility and will discharge him e) the Friend obtained a POA for the resident f) the resident agreed not to leave the building without a companion. Crossing the street alone without a companion in his	06/12/2023

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	front door to the facility, preventing the resident from leaving the facility. The Supervisor verbalized Resident #1 had Parkinson's Disease and was unsteady on the resident's feet, as a result, the staff felt the resident should not be able to leave the facility. The Supervisor explained Resident #1 did not have a Guardian and was able to make decisions on the resident's own behalf and confirmed Resident #1 was prevented from leaving the facility and verbalized it was against the resident's right to not be able to leave the facility when the resident wished to leave. Resident #1's clinical record documented the resident was responsible for themselves. The facility policy titled "Resident Rights-Policy," undated, documented all residents had the right to be free from abuse to include involuntary seclusion and physical restraint. Each resident would have the right to participate in activities, such as, community activities. The facility policy titled "Resident House Rules," undated, documented resident outings were allowed at all times, as long as it was communicated to staff and residents signed in and out on a log provided by the facility. Severity: 2 Scope: 1 Complaint #NV00067347		condition is unsafe or risky for him 2&3 The staff is aware of the Elder Abuse Law. Each month during the staff meeting and training we review safety items, incidents and other related matters with reference to what law covers the incident. This was discussed and everyone understood what happened and what should be done. Each month as incidents happen we review the circumstances and discuss what the Resident Rights are affected by an incident, 4 The Administrator is in charge of this issues, Any incident is reviewed monthly with the staff Proper steps to take are discussed in reference to an incident	
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;	0593	Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI17.	04/13/2023
0620 SS= F	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)	0620	1. I am reviewing with the doctor and nurses regarding hospice care. The hospice residents do not need 24 hour supervision of doctors or nurses. The industry needs guidance on the use of hospice in general. I was involved in the advocacy effort in CA in 1995 when hospice care was first allowed in care homes. The rationale for hospice care in care home	06/12/2023

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	Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on interview and record review, the facility failed to ensure residents receiving skilled nursing services were not allowed to admit or remain in the facility for 5 of 5 residents receiving skilled nursing services in the facility (Resident #2, #4, #7, #8, and #9). Findings include: The facility Plan of Correction dated 12/14/22, documented, "the Supervisor was responsible for identifying the need for a waiver and the Administrator will prepare the waiver." Resident #2 Resident #2 was admitted to the facility on 02/15/23, with a diagnosis of senile degeneration of brain. Resident #2's record lacked documented evidence from the Division the resident had met the requirements for eligibility to remain in the facility. Resident #4 Resident #4 was admitted to the facility on 12/20/22, with a diagnosis of left leg cellulitis. Resident #4's record lacked documented evidence from the Division the resident had met the requirements for eligibility to remain in the facility. Resident #7 Resident #7 was admitted to the facility on 05/20/21, with a diagnosis of unspecified severe protein-calorie malnutrition. Resident #7's record lacked documented evidence from the Division the resident had met the requirements for eligibility to remain in the facility. Resident #8 Resident #8 was admitted to the facility on 06/22/21, with a diagnoses of senile degeneration of brain, not elsewhere classified. Resident #8's record lacked documented evidence from the Division the resident had met the requirements for eligibility to remain in the facility. Resident #9 Resident #9 was admitted to the facility on 06/04/21, with a diagnoses of Parkinson's disease. Resident #9's record lacked documented evidence from the Division the resident had met the requirements for eligibility to remain in the facility. On 04/13/23 at 9:21 AM, the		were and still are: a) better attention to residents at end of life (no rushing to emergency hospital which is traumatic for all) b) better use of government funds (nursing home costs much much more) c) hospice care provided is really palliative care - aid comes to give shower twice a week, volunteers come weekly, and the rest of the care are left with us - nurse comes at least once a week although they are on call 24 hours I need more guidance and understanding on what documentation is needed for hospice care in order to allow them to reside in facility. If reporting to the DPBH is required every time we admit a hospice resident we will gladly do it for the next admission. If reporting and obtaining DPBH approval is needed each time we have a hospice care we will do it for the next admission. 2&3 will inform DPBH each time we have a hospice admission; ask for approval to retain the resident describing current treatment or procedures ordered by the hospice. 4. Administrator is responsible for this. Submitted all waiver requests for the identified residents (6/11/23)	

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	Supervisor verbalized the facility had not submitted exemption requests for residents receiving skilled nursing services. The Supervisor confirmed Residents #2, #7, #8 and #9 were receiving hospice services and Resident #4 was getting wound care from a home health agency. Severity: 2 Scope: 3			
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.	0885	Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI17.	04/13/2023
0895 SS= F	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 document review the facility failed to ensure an as needed medication had symptoms being treated documented on the medication administration record (MAR) for 3 of 6	0895	failed to ensure an as needed medication had symptoms being treated documented on the medication administration record 1. All records were reviewed. The MARS is generated by the Pharmacy and is documenting what the doctor ordered. I am not clear of what else to correct on this citation. attached are the cited meds. 2.& 3 focus review to ensure that symptoms are properly documented. 4. Administrator is responsible for this task. Response as of 8/15/23:See attached documents PRN medication symptom(s) obtained.	06/12/2023

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	sampled residents (Resident #1, #2, and #4). Findings include: Resident #1 was admitted to the facility on 02/03/20 with diagnoses including type II diabetes mellitus, Parkinson's disease and unsteady gait. Resident #1's MAR dated April 1, 2023 - April 30, 2023 (April), documented Baclofen tab 5 milligrams (mg), take one tablet twice a day by mouth as needed. A physician's order dated 08/19/22, documented documented Baclofen 5 mg tablet, take one tablet twice a day by mouth as needed. Resident #1's April MAR, documented ibuprofen 200 mg, take two tablets by mouth every eight hours as needed. A physician's order dated 12/17/20, documented ibuprofen 200 mg, take two tablets by oral route every eight hours as needed for pain. On 04/13/23 at 2:03 PM, the Medication Technician confirmed the resident's MAR lacked the symptoms for taking the Baclofen and ibuprofen and verbalized there should have been a reason for taking the medication. Resident #2 Resident #2 was admitted to the facility on 02/15/23 with a diagnosis of senile degeneration of brain. Resident #2's April MAR and physician's order dated 02/17/23, documented nystatin powder, apply a small amount under both breasts daily as needed. On 04/13/23 at 2:17 PM, the Medication Technician confirmed the resident's MAR lacked the symptoms for using the nystatin and verbalized there should have been a reason for taking the medication. Resident #4 Resident #4 was admitted to the facility on 12/20/22 with diagnoses including chronic kidney disease, dementia, hypertension and left leg cellulitis. Resident #4's April MAR, documented nystatin cream, apply topically to affected area twice daily. A physician's order dated 02/24/23, nystatin cream, apply topically to affected area twice daily. On 04/13/23 at 2:22 PM, the Medication Technician confirmed the resident's MAR lacked the symptoms for using the Nystatin and verbalized there should have been a reason for taking the			

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	medication. Severity: 2 Scope: 3			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were kept secured in the facility. Findings include: On 04/13/23 at 8:25 AM, the door to the medication room was open. Inside of the medication room was a medication cart with individual cups containing resident medications. There were 12 resident medication cups on top of the medication cart, the medication cart was unlocked and the medications kept in cabinets were unlocked. On 04/13/23 at 8:30 AM, the Medication Technician exited a resident hallway and walked to the kitchen before returning the the medication room. The Medication Technician confirmed all resident medications were left unsecured and accessible to all residents. The Medication Technician shrugged their shoulders when asked what would happen in a resident were to take medications not	0920	1. To keep the MedRoom always locked at all times, a keypad-lock was installed. This will require a code to open the door and the door will lock once the door is closed. see attached photo Regarding Resident #4 - keeping her nystatin powder for her underbreast, the resident is a very alert woman who requested that she keeps the powder in her room. However to date, this has been discontinued since she does not have any rashes under her breast. 2& 3 Monitor rooms to ensure that no medication is left unattended. 4. Administrator is responsible for this.	06/01/2023

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(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
	prescribed to them. The Medication Technician explained being the only Medication Technician on shift and was aware all medications were to be locked at all times in the facility. On 04/13/23 at 9:31 AM, the Supervisor explained the medication room stored all resident medications and the door to the medication room should be locked at all times. The Supervisor verbalized leaving medications unsecured was dangerous to all residents in the facility if residents took medications not prescribed to the specific resident. The Supervisor explained the Medication Technician was the only one onsite and the unsecured medications seemed to be a constant issue with this particular Medication Technician. Resident #4 Resident #4 was admitted to the facility on 12/20/22 with diagnoses including chronic kidney disease, dementia, hypertension and left leg cellulitis. On 04/13/23 at 2:18 PM, during medication review with the Medication Technician, two medications were found to be in the possession of Resident #4 in the resident's room and unsecured: - nystatin cream, apply topically to affect area twice daily - nystatin powder, apply topically to affected area four times daily On 04/13/22 at 2:22 PM, the Medication Technician confirmed the nystatin cream and powder were in the resident's room unsecured and could have been accessed by any resident. The Medication Technician verbalized medications should be secured at all times. Severity: 2 Scope: 3			
0923 SS= E	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered.	0923	This is on labeling over the counter meds 1. We reviewed all over the counter meds and reviewed all labels. We corrected where labels were needed. For Resident #1: We used the House Supply (has a label for EVCC) since the family does not want to buy the ibuprofen. We now have a separate container (newly bought) for Resident #1, properly labeled with the name of resident, meds and doctor ordering the meds.	06/12/2023

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		A. BUILDING _____ B. WING _____	**04/13/2023**

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	Inspector Comments: Based on observation and clinical record review, the facility failed to ensure an over-the-counter medication had the resident's name and physician's name on the label for 2 of 6 sampled residents (Resident #1 and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/03/20 with diagnoses including type II diabetes mellitus, Parkinson's disease and unsteady gait. Resident #1's 2023 Medication Administration Record (MAR) and physician's order dated 02/17/20, documented ibuprofen 200 milligrams (mg), take two tablets by mouth every eight hours as needed. The facility was using a stock bottle of ibuprofen. The bottle lacked the resident's name and the ordering physician's name. On 04/13/23 at 2:03 PM, the Medication Technician confirmed the ibuprofen bottle lacked the resident's name and physician's name on the bottle. Resident #5 Resident #5 was admitted to the facility on 012/30/23, with a diagnosis of late onset Alzheimer's dementia. Resident #5's April 2023 MAR and a physician's order dated 02/21/23, documented Tussin DM 10-200 mg/5 milliliters (ml), take 10 ml by mouth every eight hours as needed for cough for up to 14 days. The facility was using a house stock bottle of Tussin Dm. The bottle lacked the resident's name and the ordering physician's name. On 04/13/23 at 2:30 PM, the Medication Technician confirmed the Tussin DM bottle lacked the resident's name and physician's name on the bottle. Severity: 2 Scope: 2		For resident # 5, this has not been needed (Tussin was only needed when she had persistent cough in Feb. This meds is no longer available for the resident. 2&3 Focus review on a regular basis for labels. 4. Administrator is responsible.	

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1010 SS= F	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on record review, document review, and interview, the facility failed to obtain an endorsement for Mental Illness (MI) and admitted and retained a resident with a MI diagnosis (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 02/20/23, with a diagnosis of schizoaffective disorder, bipolar type. A Physician's Assessment for Admission dated 02/19/23, documented Resident #6 had a primary diagnosis of schizoaffective disorder. The facility lacked an MI endorsement to admit and retain residents with a MI diagnosis. On 04/13/23 at 2:40 PM, the Supervisor confirmed the facility was not endorsed for MI and verbalized Resident #6 had diagnosis of schizoaffective disorder, bipolar type. Severity: 2 Scope: 1	1010	1. All staff were trained in mental health. Certificates attached for the 8 hour training. 2. Annual training will be held after this initial training. 3. This will be scheduled every June of each year; at the anniversary of the initial training. 4. The Administrator is responsible for this task. Training completed 6/8/23.	06/08/2023
1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to	1540	1. A Cultural Competency Training for all staff members will be conducted. 2. include this training requirement in the list of training required annually. 3. Focus review of records and external audits. 4. Administrator is responsible to complete this task. 5. there is a scheduled training in July 2023.	07/15/2023

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	cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. 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 5 of 5 sampled employees requiring cultural competency training. (Employee #1, #2, #3, #4, and #5). Findings include: The facility's Plan of Correction dated 12/14/22, documented, "all employees would receive cultural competency training from an approved trainer by December 31, 2022." On 04/13/23 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 Caregiver (CG)`with a start date on 03/01/23. - Employee #2 was hired as a CG with a start date on 12/12/22. - Employee #3 was hired as CG with a start date of 01/15/23. - Employee #4 was hired as a Medication Technician with a start date of 12/15/20. - Employee #5 was hired as a CG with a start date of 09/20/10. On 04/13/23 at 11:20 AM, the Supervisor confirmed Employee #1, #2, #3, #4, and #5 had not taken an approved cultural competency training course. Severity: 2 Scope: 3		Responses as of 8/15/23 See attached training certificates for current active employees on the list.	

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1600 SS= C	Preferred Name/Pronoun P& P - R016-20 Section 19.1 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident.	1600	Please refer to original Statement of Deficiency/Plan of Correction - Event ID I5TI17.	04/13/2023