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 _____	**03/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY GROUP CARE 2	**1140 MANHATTAN STREET, RENO, NEVADA ,89512**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 03/03/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was nine. The sample size was 11 with three closed record reviews. Your facility has received a B grade for this inspection. There were two complaints investigated. Complaint #NV00066932 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: the facility failed to check a resident's blood glucose levels and administer insulin. Allegation #2: the resident was dehydrated. Allegation #3: the resident was eating cat food. The investigation into the allegations included: Observations of residents and staff interacting in resident rooms and common areas. Interviews were conducted with seven residents, two Caregivers, and the Owner. Review of the resident of concern's emergency medical service and hospital medical records. Complaint #NV00066622 with the allegation the facility gave away a resident's bed and refused to accept the resident back into the group home could not be substantiated due to lack of evidence. The investigation into the allegation included: Observations of residents and staff interacting in resident rooms and common areas. Interviews were conducted with seven residents, two Caregivers, the Social Worker, and the Administrator Reviewed the resident of concern's record, Eviction Notice, Admission Agreement, Resident Rights, group home rules, and a Serious Occurrence Report (SOR) . Deficiencies unrelated to the complaints were cited. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: WARLITO PIZARRO Title: ADMINISTRATOR Date: 05/01/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:			
0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure bedrails were not used as a restraint for 1 of 8 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 12/21/22, with diagnoses including asthenia grade 3, recurrent ovarian cancer, and debilitation. On 03/03/23 at 11:25 AM, Resident #2's bed was against the wall and had two half rails on the right of the bed, acting as a full side rail. The resident became nauseous and attempted to reach the trash can at the bedside, however the resident was unable to reach over the bed rails to retrieve the trash can. The mechanism to lower the bed rail was located on the side of the lower rail, out of reach of the resident. The resident demonstrated the resident was unable to lower the bedrail. On 03/03/23 at 12:30 PM, the Owner confirmed Resident #2 had a full bed rail on the side of their bed. The Owner explained Hospice recommended the bedrails. On 03/03/23 at 12:34 PM, the Caregiver verbalized Resident #2 would become confused and would attempt to jump out of bed to go for a walk. The Hospice nurse recommended putting the bed rails on the resident's bed to keep the Resident #2 in bed. The Caregiver explained the Caregiver kept the bed rails up when the Resident was confused to keep the resident from jumping up and	0557	TAG 0557 NAC 449.262 NRS 0302 RESTRAIN USING BED RAIL: Employee of a residential facility must NOT use (a) use restraints on any residents; (b) Lock a resident in a room inside the facility; The Administrator must ensure that the caregivers must NOT use any restraining tools like Bed rail on the bed of any resident. The Administrator instructed the caregivers stay alert of any incident, otherwise, use mattress or double heavy blankets on the floor by the bedside of the resident to protect them from any injury. Resident # 2 is already transferred to a higher level of care facility.. That the Administrator will see to it that this Restrictions on use of Restrain will not be used to confine any resident and this incident will never happen again. 04/16/2023	04/16/2023

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	getting out of bed. The Caregiver verbalized the resident was unable to exit the bed with the bed rails in the upright position. The Caregiver confirmed the bed rails were to keep the resident from exiting the bed. On 03/03/23 at 12:34 PM, the Resident verbalized the resident was unable to lower the rails themselves and was unable to get out of the bed with the rails in the up position. Severity: 2 Scope: 1			
0592 SS= H	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: (c) The residents are treated with respect and dignity; Inspector Comments: Based on interview and document review, the Administrator failed to ensure residents were spoken to in a dignified manner for 3 of 8 sampled residents (Resident #1, #2, and #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 11/02/21, with diagnoses including generalized anxiety disorder and agoraphobia with panic disorder. On 03/03/23 at 10:48 AM, Resident #4 verbalized a Caregiver called the resident a big baby when the resident complained about discomfort while the Caregiver was providing a brief change. The resident verbalized the comment made the resident feel put down by the Caregiver. On 03/03/23 at 10:49 AM, Resident #4's roommate verbalized the resident had heard the Caregiver call Resident #4 a baby. Resident #2 Resident #2 was admitted to the facility on 12/21/22, with diagnoses including asthenia grade 3, recurrent ovarian cancer, and debilitation. On 03/03/23 at 11:25 AM, Resident #2 verbalized a Caregiver had yelled at Resident #2 and made the resident cry on two separate occasions last week because the Caregiver did not want to change the resident's brief. The resident verbalized the	0592	TAG 0592 NAC 449. 268 NRS 449.0203 THAT ALL EMPLOYEES / STAFF MUST TREAT ALL RESIDENTS WITH RESPECT AND DIGNITY. That the Administrator must see to it that the employees / caregivers must treat all residents with Respect and Dignity. The Administrator advised the caregivers to be calm and show respect with smile while dealing with the residents. Never say any words that is not good to hear to residents because they are also human being that needs people who will take care of them with caring hands. The Administrator instructed the caregivers by teaching them the "ETHICS for MENTAL HEALTH PROFESSIONALS" and emphasized the importance of RESPECT AND DIGNITY to all residents and will see to it that this will never happen again. 04/16/2023	04/16/2023

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	resident felt really bad about it all day. The Resident explained the Caregiver was crabby in the morning and that was when the Caregiver would typically yell at the Resident, saying things like "God-(profanity) shut up." Resident #1 Resident #1 was admitted to the facility on 10/15/22, with a diagnosis of anxiety. On 03/03/23 11:32 AM, Resident #1 was sitting in a wheelchair in the resident's room and the resident yelled out non-words to no one in particular. On 03/03/23 at 11:32 AM, a Caregiver located in the dining room yelled at Resident #1 to shut up. Another resident was located at the dining room table and overheard the Caregiver telling Resident #1 to shut up. On 03/03/23 at 12:15 PM, the Owner verbalized it was not okay for staff to yell at residents, tell the residents to shut up, or call the residents names. On 03/03/23 at 12:15 PM, the Caregiver verbalized the Caregiver has told residents to shut up. The Caregiver explained some residents have dementia and yell out, like Resident #1. The Caregiver verbalized the Caregiver would tell Resident #1 to shut up. Residents have to be quiet in the house. The Caregiver explained when residents cursed at or verbally abused the Caregiver, the Caregiver would tell those residents to shut up. When the Caregiver was performing brief changes on a resident that would not stay still, the Caregiver would say "(Profanity) - stay still!" The Caregiver verbalized the Caregiver had taken a current Elder Abuse Training. The Caregiver explained Elder Abuse Training taught the Caregiver how to de-escalate. The Caregiver confirmed it was inappropriate to tell residents to shut up. Severity: 3 Scope: 2			

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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) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 3 of 3 residents receiving skilled nursing services (Resident #2, #3 and #4). Findings include: Resident #2 Resident #2 was admitted to the facility on 12/21/22, with diagnoses of asthenia grade 3, recurrent ovarian cancer and debilitation. Resident #3 Resident #3 was admitted to the facility on 01/20/23, with diagnoses of weakness, unable to care for self and pressure injury. Resident #4 Resident #4 was admitted to the facility on 01/20/23, with diagnoses of pressure injury, chronic obstructive pulmonary disease and diabetes. On 03/03/23 at 11:08 AM, the Owner confirmed the facility had residents receiving skilled nursing care through a hospice or home health agency. The Owner explained the Owner was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The Owner confirmed the facility had not submitted waivers to the State Agency to admit or retain residents receiving skilled nursing care. Severity: 2 Scope: 3	0620	TAG 0620 NAC 449.2702 NRS 449.0302 Except otherwise provided in 449.275 and 449.274 a residential facility shall not admit or allow to remain in in the facility any person who is Bed fast, Requires Restrains or Confinement in a locked quarters or Requires a higher level care facility to give them 24 hours caring time. The Administrator will insure and let the staff / owner that the a Residential Facility is not allowed to admit or retain any residents that need higher level of care unless the state allows by Requesting an Exemption for higher lever of care residents such as Bed fast, Wound, and more. This is also permitted by the state when the facility Request for Exemptions and apply for the Hospice Waiver. 04/016/2023 That the Administrator have known that Resident # 2 was taken by her Niece who claim to be the one responsible to take care of Resident # 2. That the Administrator have also know from the owner that Residents #3 & # 4 are now leaving the Golden Valley Group Care II and going back to live in their own apartment. 05/01/2023	04/16/2023

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0930 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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation and interview, the facility failed to ensure a discharged resident's file was retained for at least five years after the resident permanently leaves the facility (Resident #9). Findings include: On 03/03/23, requested Resident #9's file, however, the file was not located at the facility. On 03/03/23 at 11:51 AM, the Owner confirmed Resident #9's file was no longer on-site as required. Severity: 2 Scope: 1	0930	TAG 0930 NAC 449.2749 NRS 0302 MAINTENANCE AND CONTENTS OF SEPARATE FILES: That the Administrator will ensure to have a separate locker for all documents of all residents that are leaving the facility for good to have these documents filed in a locked filing cabinet and retain these documents in 5 years or more 04/16/2023	04/16/2023