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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING _____ B. WING _____ | **05/24/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOLDEN VALLEY GROUP CARE** | **2690 MARGARET DRIVE, RENO, NEVADA ,89506** |

| (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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of complaint investigations initiated at your facility on 05/24/21. The State Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was six. The sample size was three. Three complaints were investigated. Complaint #NV00063900 with the allegation the resident was transferred to another home without the permission of the resident's guardian was substantiated (See tag Y0670). Complaint #NV00063747 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1 the resident was stuck in the facility and was not allowed to leave their room, Allegation #2 the resident had a bag of medications in their room, Allegation #3 the resident was not receiving all the medications they were supposed to, Allegation #4 the resident rooms were not cleaned and smell of urine, Allegation #5: the resident's commode was not emptied frequently enough, and Allegation #6: the resident's call light was thrown away. The investigation into the allegations included: Observation of the facility, cleaning supplies, and resident rooms. Interviews were conducted with the Administrator in charge, the caregiver, and residents. Review of 4 resident files including the resident of concern. Review of the facility documents "Admission Agreement", "COVID-19 policy", and "House Rules". Complaint #NV00063817 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1 the caregiver was rough during brief changes, Allegation #2 the resident did not receive food the family brought to them and was given food they could not eat, Allegation #3 the resident requested a catheter because the resident's brief was not changed per the physician order. The investigation into the | 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: WARLITO PIZARRO Title: RFA Date: 09/02/2021

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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| | allegations included: Observation of the facility, personal care to a hospice resident, and interactions of caregivers and residents. Interviews were conducted with the Administrator in charge, the caregiver, and residents. Review of four resident files including the resident of concern. Review of the facility documents "Admission Agreement" and "House Rules". 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 deficiencies were identified: | | | |
| 0670 SS= D | Discharge of Resident; Notice of Discharge - NAC 449.2708 Discharge of resident; notice of discharge; issuance of notice to quit to resident for improper or harmful behavior. (NRS 449.0302) 1. A resident may be discharged from a residential facility without his or her approval if: (a) The resident fails to pay his or her bill within 5 days after it is due; (b) The resident fails to comply with the rules or policies of the facility; or (c) The administrator of the facility or the Bureau determines that the facility is unable to provide the necessary care for the resident.<br><br>Inspector Comments: Based on interview and document review the facility failed to receive permission to move a resident to a different facility from the resident's guardian for 1 of 7 residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 08/07/19 and discharged on 04/24/21, with diagnoses including weakness and a need for personal assistance. The facility "Admission Agreement", dated 08/07/19, documented the resident had a legal guardian. On 05/24/21 at 9:30 AM, the Caregiver/Administrator in Charge, verbalized if a resident wanted to transfer to | 0670 | TAG 0670 Discharge of Resident Notice of Discharge NAC 449.2708<br><br>That the administrator must ensure that Notice of Discharge must be given to any resident who will be transferred to another facility or for hospitalization for good or death. The facility must issue Notice of Discharge to all concerned agencies and families.<br><br>09/02/2021 | 09/02/2021 |

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| | another home and had a guardian, the guardian would be contacted to make the decision, sign the documents, and give permission for the resident to move. The Caregiver/Administrator in Charge confirmed the documentation on file did not indicate the guardian had been contacted to coordinate or approve the move of Resident #7 to another facility. A facility "Nevada DHCFP Serious Occurrence Report", dated 04/30/21, documented the resident was moved to another facility per the resident's request to be closer to town and have a room closer to the smoking area. The document indicated the guardian was notified on 04/30/21, via telephone. A facility "Resident Discharge/Transfer Form", dated 04/24/21, documented the Public Guardian was notified of the residents move via telephone. The facility documentation lacked documented evidence of the Public Guardian giving approval for the resident to move to another group home. | | | |