STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	03/16/2021

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 Inspector Comments: This Statement of Deficiencies was generated as a result of a FOCUSED COVID-19 infection control survey conducted at your facility on 03/16/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illness, Category II residents and provides assisted living services. The census at the time of the survey was 8. Upon entry the Administrator verbalized the following: - No staff members tested positive or were symptomatic for COVID-19. - No residents tested positive or were symptomatic for COVID-19. The investigation of regulatory compliance of Infection Control and Prevention included the following: Observations: Postings notifying the public of facility visitation restrictions, the mandatory use of hand washing, hand sanitizing, and the use of masks were on the entry door of the facility. Upon entry to the facility the surveyors were not screened for signs and symptoms of COVID-19; however, the Administrator verbalized all visitors were required to be screened upon entry, were required to wear masks and temperatures taken (See Tag #0593). A visitor log, a pump container of hand sanitizer, an infrared thermometer and extra copies of the COVID-19 signs and symptoms questionnaire were available on an entryway table. In a filing cabinet, next to the front entry were 3 boxes of medium sized gloves, 2 boxes of surgical masks and two N95 masks. All caregivers were wearing masks and were observed using Alcohol Based Hand Sanitizer (ABHS) during the survey. Residents had surgical masks provided by the facility to wear if they left their rooms, however, the facility did not require residents to wear masks when leaving their rooms. ABHS was located throughout the facility including at the entry door, in the dining room, the bathrooms, and common living areas. The Caregivers were using bleach-based water solution to	0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	03/16/2021

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
	wipe commonly touched surfaces a minimum of twice daily. The facility's personal protective equipment in stock included 12 disposable gowns, 3 boxes of surgical face masks, 3 boxes of gloves, face shields, and two N95 masks. There was not an inventory sheet completed to be able to track PPE usage in the facility (See Tag Y0593). Interviews: The Owner verbalized temperature logs were maintained daily and residents were monitored once a day for signs and symptoms of COVID-19 including shortness of breath, congestion or runny nose, muscles or body aches, nausea, vomiting, sore throat, new or worsening cough, new or worsening fatigue, new or worsening headache, new or loss of taste or smell and new or worsening diarrhea. The Owner verbalized there were not any employees, except for a part time Caregiver, who had a N95 medical clearance and fit testing completed (See Tag Y0593). The Administrator was able to describe the signs and symptoms of COVID-19, when to isolate a resident, when to call the physician, when to call 911, and what PPE to use when caring for COVID-19 infected residents; however, the Owner could not explain when to properly change Personal Protective Equipment (PPE) while caring for COVID-19 positive residents (See Tag Y0593). The Administrator explained visitation into the facility was permitted and had visitors up to and including on 03/15/21. All resident's in the facility at the time of the survey verbalized they had no complaints of illness, had not experienced signs or symptoms of COVID-19, and confirmed they had not had any illnesses in the last 30 days. Six out of the eight residents received their first dose of the COVID-19 vaccine on 01/27/21 and received the second vaccine on 02/17/21. Two residents refused to receive the COVID-19 vaccine. The Owner produced one training completed for all staff. The training was PPE training, completed for all staff on 10/26/20. The Owner explained the training covered what PPE to use in case of a COVID-19 outbreak in the facility and no other trainings had been completed by staff (See Tag #0593). The Owner verbalized all staff were aware of proper handwashing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	03/16/2021

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
	techniques, although, no formal trainings were given to staff. The Owner was not able to demonstrate proper hand washing techniques and could not describe a proper hand washing time (See Tag #0593). The Owner explained in the case of a COVID-19 outbreak emergency, the part time employee would be required to care for residents. There was not a written plan to describe processes in the case of a COVID-19 outbreak (See Tag Y0593). Document Review: The facility had a comprehensive COVID-19 Infection Control Policy. The resident temperature logs. The facility visitor logs. The facility COVID-19 signs and symptoms questionnaires. The N95 FIT testing and medical clearance for one part time employee. The Infection Control and Prevention Plan. The Respiratory Protection Program COVID-19 Response. The Corona Virus (COVID-19) Policy. 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:			
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, interview, and record review, the facility was unable to provide a safe environment for 8 of 8 residents residents by the following: 1) Did not ensure visitors to the facility were screened for temperature and signs and symptoms of COVID-19 (COVID). 2) Did not have documented staff training on the CDC recommended PPE and donning/doffing procedures for the PPE used in the care of COVID-19 positive or presumptive residents and staff training for proper handwashing. 3) Did not follow the	0593	TAG 0583 Right of Residents; NAC 449.268 NRS 449.0202 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment: That the administrator must see to it and ensure that all caregivers and staff must always enforce to all personnel and visitors coming in the facility including all residents who are coming from their appointments and/or from their families to conduct the SCREENING Process of the SIGNS AND SYMPTOMS of COVID-19 (CORONAVIRUS) and their TEMPERATURES. The administrator also ensure that the PERSONAL PROTECTIVE EQUIPMENT TRAINING was conducted to all caregivers including PPE Donning and Doffing, Hand washing, everyday washing and disinfecting of all highly toucheable parts of the facility such as door knobs,	09/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	03/16/2021

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
	documented facility N-95 Respirator Program and Policy to have staff Fit tested for the N-95 respirator mask. 4) Did not ensure PPE was properly tracked to determine available quantities in the case of a COVID outbreak. 5) Did not ensure a proper cohorting plan was created. Findings include: Health Screening On 03/16/21 at 9:30 AM, upon entry, two of two State Surveyors were not screened for signs and symptoms of COVID and temperatures were not taken. On 03/16/21 at 9:30 AM, the Owner verbalized all visitors were required to be screened upon entrance to the facility. Visitor screening consisted of a temperature check, a health questionnaire and the visitors had to wear a mask. The Owner confirmed the State Surveyors were not screened upon entrance to the facility and should have been screened upon entrance to the facility. The facility policy titled "Infection Control and Prevention Plan-COVID-19 Response," effective October 25, 2020, documented the facility would have one point of entrance and would ensure proper screening techniques were used to include a questionnaire and temperature check before being allowed to enter the facility. Staff Training On 03/16/21 at 9:30 AM, the Owner verbalized no staff have been trained on how to properly don and doff PPE, staff were not trained on the type of PPE to use if a resident were to be positive for COVID and staff were not trained on proper hand washing techniques. The Owner was not able to properly demonstrate proper handwashing techniques, could not provide a proper hand washing time in order to disinfect the hands, could not demonstrate proper PPE donning and doffing procedures and could not verbalize an understanding of proper PPE usage for caring for COVID positive residents. The Owner confirmed staff were not trained on the proper donning and doffing techniques, staff were not trained for proper handwashing techniques and confirmed staff did not know what PPE to use to care for COVID positive residents. The facility policy titled, "Infection Control and Prevention Plan, Coronovirus Disease 2019 (COVID-19) Response," dated October 25, 2020, documented PPE		handles and more. The administrator also ensure that there are more than enough available quantities of PPE in the facility in case of a COVID-19 outbreak. This facility have private rooms for all residents so isolation and cohorting plan was already initiated. 09/02/2021 The following attachments were Forms of previous copies of the sign and symptoms with Temperature including photographed to show and determine that all necessary requirements for COVID-19 are followed and provided by the facility. The other attachments are the PPE TRAINING CERTIFICATES that were conducted by the new administrator who assumed April 1, 2021 after the survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	03/16/2021

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
	training would include proper donning and doffing techniques, when to use the proper PPE in case of a COVID outbreak and proper handwashing techniques. FIT tests On 03/16/21 at 9:30 AM, the Owner verbalized all staff were FIT tested, however could not provide copies of a FIT test. The Owner explained not knowing exactly what a FIT test was, why it was important for the use of an N95 mask, nor the process of being FIT tested. On 03/16/21 at 10:12 AM, the Owner provided a FIT test for one part time employee dated 11/10/20 and confirmed no other staff had been FIT tested. The facility policy titled, "Infection Control and Prevention Plan, Coronovirus Disease 2019 (COVID-19) Response," dated October 25, 2020, documented the Administrator would ensure each caregiver would complete a FIT test before using N95 masks and proper training would be provided on an annual basis. The facility policy titled, "Respiratory Protection Program," dated September 10, 2020, documented all staff would be properly FIT tested annually and as needed should the type of N95 mask change. The FIT tests would be conducted prior to being allowed to wear a respirator, if there were changed of the respirator product, if staff changed more than 10% of their weight or facial structure and as Occupational Safety and Health Administration (OSHA) standards required. PPE Inventory Tracking On 03/16/21 at 9:30 AM, the facility had PPE on site to include: -Twelve gowns -Three boxes of surgical masks. There were 50 masks in each box. -One box of faceshields. -Two N95 masks. A PPE tracking log could not be located. On 03/16/21 at 9:54 AM, the Owner verbalized the PPE on site had been being used daily, wasn't sure how much PPE was on hand and did not have a way to track PPE. The Owner confirmed there was no PPE Inventory Tracking sheet. The facility policy titled, "Infection Control and Prevention Plan, Coronovirus Disease 2019 (COVID-19) Response," dated October 25, 2020, documented to track the use of PPE and order before running out. It was imperative the facility had enough PPE to prevent the spread of COVID-19. Cohorting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205	A. BUILDING _____ B. WING _____	03/16/2021

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
	Plan On 03/16/21 at 10:12 AM, the Owner verbalized the facility did not have a documented plan to address how residents would be cohorted (grouped) if they tested positive for the virus. The facility policy titled, "Infection Control and Prevention Plan, Coronovirus Disease 2019 (COVID-19) Response," dated October 25, 2020, documented the facility would designate one or more caregivers to ensure resident's vitals were taken daily to rule out COVID. If COVID was identified or suspected, a resident would immediately be isolated to their room and the resident's physician and health department would be notified, a space in the facility would be identified to be able to dedicate care to a resident with a confirmed COVID diagnosis to lessen exposure to other residents, a plan would be created on how to care for a resident with COVID and an ill resident could possibly remain in the facility isolated, once a level of care was determined. Severity: 2 Scope: 3			