Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON GROUP CARE #1	1895 CARVILLE DR, RENO, NEVADA ,89512

(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 an annual, State Licensure survey conducted at your facility on 08/05/20. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category 1 residents. The census at the time of the survey was five. The facility received a grade of C. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

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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 and interview, the administrator failed to ensure non-essential visitors were not entering the facility during a pandemic and visitors were screened for temperature and symptoms of COVID-19 at the entrance to the facility. Findings include: On 08/05/20 between 8:30 and 9:00 AM, three visitors entered the facility and did not have temperatures checked and were not asked about signs and symptoms of COVID-19. The visitors were not wearing facial coverings and were not social distancing from the facility residents. On 08/05/20 at 9:35 AM, the Caregiver verbalized the visitors were residents from another facility and would come to the facility everyday. The visitors would arrive at the facility by 10:00 AM and would stay until at least 3:00 PM. On 08/05/20 at 10:14 AM, the Administrator verbalized the visitors had been spending the day at the facility since mid to late March of 2020. The Administrator verbalized all visitors were supposed to be screened on entrance and required to wear a facial covering. Severity: 2 Scope: 3	0050	#0050 Effective immediately the administrator will ensure the following: • only essential visitors will be allowed to visit • all essential visitors will have their temperature checked and screened for symptoms • all visitors must wear a mask or face covering	09/02/2020
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 the common hallway area was maintained and the outside premise was maintained free of debris. Findings include: On	0178	#0178 Effective immediately the administrator will ensure • the waiting room and hallway are clutter free and all furniture is dusted • business mail is stored properly • bags of empty medication bubble packs are put in the trash The missing baseboard and the small hole in the ceiling was repaired 8/5/2020	09/02/2020

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	08/05/20 at 8:34 AM, the living room area was cluttered and contained following items stored: - Two boxes filled with documents and private mail; an envelope full of cash - A large garage vacuum cleaner - Furniture was dirty - A large heavy trash container filled with empty medication bubble packs On 08/05/20 at 8:47 AM, the Administrator verbalized the clutter in the living room and expressed the empty bubble pack medication needed to be throw into the trash. The Administrator expressed the house was a mess because her mother had passed away and the Administrator was cleaning. On 08/05/20 at 8:58 AM, the backyard was observed to have the following items stored and were leaning against the side of the house: - Several boxes filled with trash, patio furniture, furniture, and landscaping supplies - Boxes filled with clothes - Several containers filled with shoes - Multiple containers filled with clothes - Several bags and boxes filled with trash - A container filled with plates and dishes - Several plastic storages containers On 08/05/20 at 9:00 AM, the Administrator explained the backyard needed to be cleaned and expressed she was going to call the thrift store to come and pick up the boxes and containers. On 08/05/20 at 10:06 AM, in the common area in the hallway was missing the baseboard trim and had damaged drywall. On 08/05/20 at 10:06 AM, the corner ceiling in the hallway there was one hole and damaged drywall. On 08/05/20 at 11:09 AM, the Administrator expressed the missing baseboard trim, the hole in the corner ceiling, and the damaged drywall. The Administrator indicated the inside of the house and backyard needed to be repaired and cleaned up. Severity: 2 Scope: 3			

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0370 SS= D	Housing for staff members - NAC 449.224 Housing for staff members. (NRS 449.0302) 1. Bedrooms must be provided for any members of the staff of a residential facility and their families who live at a residential facility. The bedrooms must comply with the provisions of subsections 2 to 8, inclusive, of NAC 449.218 and the provisions of NAC 449.220 and 449.221. Inspector Comments: Based on observation and interview, the facility failed to ensure one staff member was provide appropriate housing 1) bedroom with a door 2) bedroom including a used for another purpose (Employee #2). Findings include: On 08/05/20, during a facility tour it was observed the caregiver did not have a bedroom. On 08/05/20, during a tour of the facility a twin bed was located next to the front door, obstructing the entry way. Employee #2 indicated they slept on the bed seven nights per week and lived at the facility. On 08/05/20 at 8:45 AM, Employee #2 expressed they lived in the home and indicated she slept on the twin bed located next to the door. This was a talking point from the 11/26/19 annual State Licensure survey. Severity: 2 Scope: 1	0370	#0370 Effective immediately the administrator has made arrangements to remove the daybed from the waiting room area the staff member will sleep in the assigned bedroom at the back of the facility	09/02/2020

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0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure residents received annual physical examinations for 2 of 5 residents (Resident #2 and #4). Findings include: Resident #2 Resident #2 was admitted to the facility on 06/20/11 with diagnoses including schizophrenia. The resident's medical record documented an annual physical examination, dated 03/26/19. The record lacked documented evidence the resident had received a general physical examination, since 03/26/19 and; therefore, had not obtained the required examination within the previous 12 months. Resident #4 Resident #4 was admitted to the facility on 02/13/13 with diagnoses including schizophrenia, dyslipidemia, and hypothyroidism. The resident's medical record documented an annual physical examination, dated 02/13/19. The record lacked documented evidence the resident had received a general physical examination, since 02/13/19 and; therefore, had not obtained the required examination within the previous 12 months. On 08/05/20 at 9:46 AM, the Administrator confirmed the missing physical examinations and was unable to provide documented evidence of a physical examination completed for Resident #2 and #4. Severity: 2 Scope: 2	0859	#0859 The facility acknowledges this discrepancy how ever due to the COVID-19 Physicians were not scheduling appointments. The administrator will ensure when appointments can be scheduled appointments will be made for physicals.	09/03/2020
0870 SS= F	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents	0870	#0870 The facility acknowledges this how ever due to COVID – 19 Physicians were not	09/03/2020

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	in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 4 of 5 sampled residents residing in the facility for longer than six months (Resident #1, #2, #3, and 4). Findings include: Resident #1 Resident #1 was admitted to the facility on 11/12/93 with diagnoses including knee pain, hypothyroid, depression, and schizophrenia. Resident #1's medical record lacked documented evidence of a six-month pharmacy review had been conducted. Resident #2 Resident #2 was admitted to the facility on 06/20/11 with diagnoses including schizophrenia. Resident #2's medical record lacked documented evidence of a six-month pharmacy review had been conducted. Resident #3 Resident #3 was admitted to the facility on 06/14/18 with diagnoses including schizophrenia. Resident #3's medical record lacked documented evidence of a six-month pharmacy review had been conducted. Resident #4 Resident #4 was admitted to the facility on 02/13/13 with diagnoses including schizophrenia, dyslipidemia, and hypothyroidism. Resident #4's medical record lacked documented evidence of a six-month pharmacy review		scheduling appointments. The administrator willensure to schedule appointments when they are allowed.	

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	had been conducted. On 08/05/20 at 10:11 AM, the Administrator confirmed the pharmacy reviews had not been completed annually and was unaware of the requirement for pharmacy reviews to be completed at least once every six months. Severity: 2 Scope: 3			
0895 SS= C	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 record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 4 of 5 residents (Resident #1, #3, #4 and #5). Findings include: Resident #1 Resident #1 was admitted on 11/12/93 with diagnoses including knee pain, hypothyroid, depression, and schizophrenia. The resident's current physician order, dated 07/01/20, documented Stool Softener 100 milligrams (mg), take two capsules by mouth once daily. The label on Resident #1's medication, documented Stool Softener 100 mg, take two capsules by mouth once daily. Resident #1's August 2020, MAR documented Stool Softener 250 mg, take one capsule by mouth once daily. On 08/05/20 at 10:48 AM, the Administrator confirmed the MAR was not accurate with the physician's order and the facility was administering two capsules daily. Resident #3 Resident #3 was admitted to the facility on 06/14/18 with diagnoses including schizophrenia. The resident's current physician order, dated 07/27/20,	0895	#0895 The administrator inadvertently placed wrong labels on the MARS this was corrected. Effective immediately the administrator will provide training to ensure accuracy on completing MARS.	09/03/2020

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	documented Vitamin B6 50 mg, take one tablet by mouth daily. The medication available to the resident was not documented on the August 2020 MAR compared with the physician's order. On 08/05/20 at 11:16 AM, the Administrator confirmed the resident's MAR was missing the Vitamin B6 documentation at the time of the medication review. Resident #4 Resident #4 was admitted to the facility on 02/13/13 with diagnoses including schizophrenia, dyslipidemia, and hypothyroidism. The resident's current physician order, dated 07/27/20, documented Atropine Sulfate Opthalmic Solution 1% 5 milliliter (ml), put three drops under the tongue at bedtime. The label on Resident #4's medication, documented Atropine Sulfate Opthalmic Solution 1% 5 ml, put three drops under the tongue at bedtime. Resident #4's August 2020, MAR documented Atropine Sulfate 1% Solution, use one - two drops under tongue at bedtime for drooling. On 08/05/20 at 11:01 AM, the Administrator confirmed the MAR was not accurate with the physician's order and the facility was administering three drops at bedtime. Resident #5 Resident #5 was admitted to the facility on 08/23/19 with diagnoses including schizophrenia, diabetes, high cholesterol, and chronic pain. The resident's current physician order, dated 07/16/20, documented Clozapine 200 mg, take 1.5 tablets (300 mg) by mouth at bedtime. The label on Resident #5's medication, documented Clozapine 200 mg, take 1.5 tablets (300 mg) by mouth at bedtime. Resident #5's August 2020, MAR documented Clozapine 100 mg, take three tablets (300 mg) by mouth nightly at bedtime. On 08/05/20 at 10:37 AM, the Administrator confirmed the MAR was not accurate with the physician's order and the facility was administering 1.5 tablets at bedtime. Severity: 1 Scope: 3			