

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>240</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/26/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JOHNSON GROUP CARE #1</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1895 CARVILLE DR, RENO, NEVADA ,89512</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                  | <p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as the result of a State Licensure COVID-19 Infection Control and Prevention Plan follow-up Survey conducted in your facility on 08/26/20. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for 6 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 5. A review of the facility's Infection Control and Prevention Plan revealed the facility had the following components documented and ready for implementation: -A verbal interview with the Administrator and a Caregiver describing implementation of the plan. -Visitor entry and facility screening practices -An Emergency Staffing Plan if a staff member tested positive -A plan if a resident tested positive -Access to or inventory of Personal Protective Equipment (PPE) -Staff training on the proper use of PPE to include donning and doffing -Scheduled Staff Fit Tests for N-95 masks -Respirator Program - Identification and response to residents with suspected or confirmed COVID-19 -New Admissions or Readmissions with an unknown COVID-19 status -Required notifications The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were identified.</p> |                                                                                           |                                                                                                                          |                                                        |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
REPRESENTATIVE'S SIGNATURE