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 _____	09/23/2020

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 a Wellness Visit survey conducted in your facility on 09/23/20. This Wellness Visit 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 nine. Nine resident files were reviewed. 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		
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, interview, record review, and document review the Administrator failed to ensure the facility did not admit more residents than the specified number on the facility's license. Findings include: On 09/23/20 at 11:45 AM, the Administrator confirmed the facility census was nine and the facility was only licensed for a total of six beds (See Tag Y0087). Severity: 2 Scope: 3	0050	#0050 The administrator allowed residents from Johnson Group Care II to reside at Johnson Group Care I due to the eruption of a fire at Group Care II and the facility being evacuted by the Reno Fire Department. The residents were evacuated. The adminstrator contacted the Northern Nevada Adualt Mental Health Services and was instruced to house them at Group Care number I. The residents were moved due to the emergency of the situation. The adminstrator was not aware she was to call the Ombudsman. Effective immediately the adminstrator will ensure emergency housing needs the Ombudsman wii be contacted.	10/02/2020
0087 SS= F	Limitation on Number of Residents - NAC 449.199 Staffing requirements 3. A residential facility must not accept residents in excess of the number of residents specified on the license issued to the owner of the facility.	0087	#0087 The adminstrator allowed the residenys of Johnson Group Care II to Move into Johnson Group Care I, due to an emergency evacuation by Reno Fire Department because of a fire.	10/02/2020

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 _____	09/23/2020

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
	Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure the number of residents at the time of the survey did not exceed the specified number on the facility's license.. Findings include: The facility was licensed for a total of six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category 1 residents. On 09/23/20 at 11:45 AM, the Administrator confirmed there were a total of nine residents requiring and receiving room and board, meals, assistance, and limited supervision. (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9). Resident #1 was admitted to the facility on 09/02/20, with diagnoses including schizophrenia. Resident #1 required supervision and assistance with medication administration. Resident #2 was admitted to the facility on 09/02/20, with diagnoses including schizophrenia. Resident #2 required supervision and assistance with medication administration. Resident #3 was admitted to the facility on 09/02/20, with diagnoses including schizophrenia. Resident #3 required supervision and assistance with medication administration. Resident #4 was admitted to the facility on 09/02/20, with diagnoses including schizophrenia. Resident #4 required supervision and assistance with medication administration. Resident #5 was admitted to the facility on 11/12/93, with diagnoses including schizophrenia and knee pain. Resident #5 required supervision and assistance with medication administration. Resident #6 was admitted to the facility on 06/20/11, with diagnoses including schizophrenia. Resident #6 required supervision and assistance with medication administration. Resident #7 was admitted to the facility on 08/23/19, with diagnoses including schizophrenia and diabetes. Resident #7 required supervision and assistance with medication administration. Resident #8 was admitted to the facility on 02/05/13, with diagnoses including schizophrenia and dyslipidemia. Resident #8 required supervision and assistance with medication administration. Resident #9 was admitted to		Effective immediatly even the administrator contacted Northern Nevada Adult Mental Services she will ensure the ombudsman is contacted.	

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 _____	09/23/2020

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
	the facility on 06/14/18, with diagnoses including schizophrenia. Resident #9 required supervision and assistance with medication administration. On 09/23/20 at 11:46 AM, the Administrator verbalized Residents #1, #2, #3, and #4 had moved into the facility on 09/02/20 after a fire, in a group home the resident's were residing in, required the resident's to move. The Administrator verbalized the Administrator had not contacted the Ombudsman's office to assist with placement prior to admitting the residents to the facility. Severity: 2 Scope: 3			