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 |
|---|---|---|---|
| | 3659 | A. BUILDING _____ B. WING _____ | 09/22/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KRYSTONS HOME CARE 2 | 7990 ZINFANDEL 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 an annual State Licensure Survey conducted in your facility on 09/22/22. 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 six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or intellectual disabilities, Category II residents. The census at the time of the survey was five. Five resident files and four employee files were reviewed. The facility received a grade of A. 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: | 0000 | | |

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 REPRESENTATIVE'S SIGNATURE | Name: THELMA FRIAS | Title: Owner/Mgr | Date: 10/17/2022

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| 0102 SS= D | Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee;<br><br>Inspector Comments: Based on personnel record review and interview, the facility failed to ensure a caregiver completed a physical examination prior to providing care to residents for 1 of 4 employees (Employee #4). Findings include: Employee #4 Employee #4 was hired as a caregiver on 06/16/21. The employee's personnel record lacked documented evidence of a completed pre-employment physical. On 09/22/22 at 1:15 PM, the Owner/Caregiver confirmed Employee #4 had been providing care to residents since 06/16/21 but had not yet completed a pre-employment physical. The Owner/Caregiver verbalized a pre-employment physical should have been completed prior to Employee #4 being scheduled to provide care to residents. Severity: 2 Scope: 1 | 0102 | Based on personnel record and interview, employee number 4 did not have a physical exam upon hiring on 6/16/2021. The employee submitted an Osha Respirator Clearance Examination which consist of medical test assuming that it's already a physical. Since this not acceptable or considered as a physical ,the employee now is scheduled to see a doctor for a physical and the facility is now aware about the basic physical exam upon hiring an new employee to ensure the deficient practice will not recur. The Administrator is responsible for ensuring the plan of correction is implemented and monitor for compliance. | 10/17/2022 |

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| 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;<br><br>Inspector Comments: Based on observation, document review, and interview, the Administrator failed to ensure a safe environment for 5 of 5 residents by not ensuring visitors to the facility were screened for temperature and signs and symptoms of COVID-19 (COVID). Findings include: On 09/22/22 at 9:42 AM, upon entry to the facility, all three State Surveyors were not screened for signs and symptoms of COVID-19. The COVID-19 screening log located on a table in the living room documented the last visitor to the facility was screened on 05/27/22. On 09/22/22 at 9:45 AM, the Owner/Caregiver confirmed visitors entering the facility were not screened for temperature or signs and symptoms of COVID-19 placing the residents at risk of infection. Severity: 2 Scope: 3 | 0593 | Based on the observation, document review and interview on 9/22/2022, the facility should screened all visitors entering the facility the signs and symptoms of covid-19 to ensure a safe environment for the residents and other employees not placing at risk of infection to ensure the deficient practice will not recur. Employees are now aware to start screening the signs and symptoms again to all visitors entering the facility which they used to do it awhile ago. The Administrator is responsible for ensuring the plan of correction and monitor for compliance. | 10/11/2022 |