STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4009	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTLE SPRING CARE HOME	6418 SPRING MEADOW DRIVE, LAS VEGAS, NEVADA ,89103

(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 COVID-19 focused infection control survey and annual State Licensure survey initiated at your facility on 08/04/20. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, Category II residents. The census at the time of the survey was seven. The facility received a grade of A. The focused COVID-19 infection control survey included the following: Observations: - Facility staff checked the temperature of the health facility inspector prior to entry to the facility. - The health facility inspector was not required to answer COVID-19 screening questions related to: symptoms, travel history, and exposure to the virus at other facilities prior to entry to the facility. (TAG 0500) - The health facility inspector was asked to use hand sanitizer prior to entry to the facility. - One resident was in the living room on the couch; One resident was at the kitchen table; five other residents were in their bedrooms, and maintaining social distancing. - Staff disinfected kitchen counters and front door knobs with Lysol disinfectant spray. - Two caregivers wore surgical masks and gloves while providing care. - One 40 fluid ounce bottle of hand sanitizer was located at the main entrance and one 67 fluid ounces bottle in the living room. Interview: - The caregiver verbalized temperature checks were completed for staff and healthcare workers upon entrance to the facility. - Temperature checks for residents are conducted twice each day. - Medical professionals are the only persons allowed entry into the facility. - Residents and staff have not been tested for COVID-19 and have not exhibited signs or symptoms. - Three residents were served meals in the dining room/kitchen, while other residents were served meals in their rooms to promote social distancing. -	0000		

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	Activities were provided in bedrooms and in living room to adhere to social distancing. - Staff sanitized all high touch areas three times a week with Lysol. - The facility had one box of 100 surgical masks; four boxes of 100 gloves; and one electronic temporal thermometer. - No training was held for staff on proper personal protective equipment (PPE). (TAG 0050) Record Review: - Infection Control Program policies and procedures documented measures to ensure isolation and prevention of COVID-19. - Standard and transmission based precautions for COVID-19. - Visitor entry and facility screening practices including: screening questions, hand sanitization and temperature checks. - Education, monitoring and screening practices of staff including: proper PPE use, temperature checks, hand washing and sanitization. - Facility policies and procedures to address staffing issues during emergencies, such as the transmission of COVID-19. 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:			

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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 did not ensure visitors of the facility were screened for COVID-19 according to CDC guidelines prior to entry to the facility and the facility staff have not been trained on personal protective equipment (PPE). Findings include: On 08/04/20 at approximately 9:00 AM, The Caregiver did not ask COVID-19 screening questions of the health facilities inspector prior to entry to the facility. The Caregiver verbalized all visitors inside the facility have their temperature checked but the facility does not ask screening questions. On 07/28/20 at approximately 9:25 PM, the Caregiver reported facility staff were not trained on proper donning and doffing of PPE. Severity: 2 Scope: 3	0050	Tag 0050 1. All visitors that come to the facility, the staff will now ask Covid-19 screening questions on questionnaire prior to entry to the facility and take visitor temperature prior to entry. (See attachment) 2. The staff was trained on proper donning and doffing PPE, and the visitor Covid -19 questionnaire, temperature log. The questionnaires that were answered by all visitors will be placed in a binder. This will ensure the deficient does not recur. (See attachments) 3. The administrator will monitor the corrective action when she visits the facility to ensure staff is using the Covid -19 visitor questionnaire and using proper techniques on PPE. this will ensure this deficient practice does not recur. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of Compliance: 8/6/20	08/06/2020
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in	0878	Tag 0878 1. Resident #1 medication Vitamin D 1000 unit was in the medication bin, and not on the August MAR. The staff has given the Vitamin D as prescribed but caregiver forgot to add to the August MAR. 2. The medication for Resident #1 was immediately recorded on MAR. All medications prescribed by a residents physician will be added to the current month on MAR. 3. The administrator will monitor the MAR to ensure all medications are recorded as prescribed, this will ensure the deficient does not recur. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of Compliance: 8/4/20	08/04/2020

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	the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview and record review the Administrator failed to ensure medication was documented on a resident's Medication Administration Record (MAR) for 1 of 7 resident (Resident #1). Findings include: Resident #1 (R1) was admitted to the facility on 03/22/20, with diagnoses including vascular dementia and metabolic encephalupathy. On 08/04/20 at 11:15 AM, vitamin D 1000 unit capsules were in R1's medication bin, and the medication was not on the August MAR. Caregiver stated he gave R1 their vitamin D as prescribed but had forgotten to add it to the August MAR. R1's medication order was to take 1 capsule by mouth daily. Severity: 2 Scope: 1			

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0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on observation, interview and record review, the facility failed to complete initial activities of daily living (ADL) screenings for 1 of 7 residents (Resident #7). Resident #2 (R2) was admitted on 04/15/20, there was no documented evidence an initial ADL was completed for the resident. Caregiver revealed R2 did not have an ADL assessment complete. Severity: 2 Scope: 1	0938	Tag 0938 1. The initial activities of daily living (ADL) screenings for Resident #7 & Resident #2 were completed.pm 8/5/2020. (See attachments) 2. New residents that move in will now have a needs assessment completed at time of the move in. 3. The administrator will monitor the residents files to ensure a needs assessment is completed on move in and if there is a physical or a mental change of condition. Needs assessments will be done yearly on all residents. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of compliance: 8/5/2020	08/05/2020