

Division of Public and Behavioral Health

|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>4406</b>                                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/08/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>V N SENIOR CARE OF THE VINEYARDS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1931 W VINEYARD DRIVE SOUTH, PAHRUMP, NEVADA ,89048</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)<br><br><b>Initial Comments</b><br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and infection control survey conducted at your facility on 05/08/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was six. Six 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 investigation, 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: | 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                             |
| <b>0451<br/>SS= F</b>                                                       | First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure a first aid kit was readily available. Findings include: On 05/08/23 in the afternoon, three of three caregivers working in the facility could not locate a first aid kit on the premises, nor were all of the required items for a first aid kit available. On 05/08/23 in the afternoon, the Owner acknowledged the facility did not have a first aid kit. Severity: 2<br>Scope: 3                                                                        | <b>0451</b>                                                                                             | 1. To correct a specific deficiency, we have purchased a new first aid kit.<br>2. To make sure that this deficiency will not be occur, the owner and Lead Caregiver will check the first aid kit on a regular basis to make sure that is available at all times.<br>3. The corrective action will be monitored by the Lead Caregiver and Owner by checking it at least every quarter.<br>4. The responsible persons to make sure that the plan of correction is implemented are the owners and the Lead Caregivers.<br>5. Corrective action was done on May 20, 2023<br>6. Please see attach pictures of the new first aid kit. | <b>05/23/2023</b>                                      |

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: CHARO DALE Title: Provider 's Representative Date: 05/23/2023  
REPRESENTATIVE'S SIGNATURE