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
	444	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING HEIGHTS	2397 EMPIRE RANCH ROAD, CARSON CITY, NEVADA ,89701

(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 the result of a follow-up State Licensure COVID-19 Infection Control and Prevention Plan Survey initiated in your facility on 08/18/20 and completed on 08/25/20. 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 eight Residential Facility for Group who are elderly or disabled persons, Category II residents. The census at the time of the survey was six. There were no positive or presumptive Covid-19 residents or staff at the time of the survey. The facility utilized the front entrance as the main access point. All staff members and essential healthcare providers were required upon entry to complete a verbal questionnaire for COVID-19 signs and symptoms, have their temperature taken, instructed to wear a surgical mask and to use an alcohol based hand sanitizer. A visitor log was located at the front entry and listed visitor names and temperatures. Observed staff to wear masks and gloves with all resident care and facility duties. All residents were observed to be socially distanced in the common area and the dining area. An interview conducted with a Caregiver revealed the facility maintained an adequate supply of the following personal protective equipment: disposable gowns, gloves, surgical masks, and N95 masks. The Owner verbalized an appointment with Nevada Occupational Health had been scheduled for the N95 mask Fit test. Residents were screened for temperature and signs and symptoms of Covid-19 twice weekly and logged. Staff members were screened daily for temperature, a verbal questionnaire, and then logged. The facility provided continuing education on Infection Prevention and Control Training to staff members through weekly phone calls and review of Centers for Disease Control guidelines. A review of the facility's Infection Control and Prevention Plan revealed the facility had the following components documented and	0000		

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	ready for implementation: The review of the plan included the following: - A verbal interview with Administrator 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 - Staff Fit Tests for N-95 masks-scheduled with Nevada Occupational Health - 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.			