

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2021
NAME OF PROVIDER OR SUPPLIER WHISPERING HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a result of an annual State Licensure survey conducted in your facility on 08/06/21. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facilities for Groups. The facility was licensed for eight Residential Facility for Group beds for elderly and disabled persons, eight Category II residents. The census at the time of the survey was five. Five resident files were reviewed and two employee files were reviewed. The facility received a grade 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:	0000		
0102 SS= A	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; Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure employees met the requirements concerning tuberculosis (TB) testing for 1 of 2 employees (Employee#1). Findings include: Employee #1 Employee #1 was hired as an Administrator, with a start date of 10/06/11. The employee file contained TB testing dated 01/29/20, and 07/19/21 both with negative results. The 2021 TB test was late. On 08/06/21 at 10:37 AM, the Administrator acknowledged Employee #1 2021 annual TB test was late and confirmed Employee #1 should have had another two step TB test in 2021. Severity: 1 Scope: 1	0102		08/17/2021

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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(X4) ID PREFIX TAG 0106 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure caregivers were certified to perform cardiopulmonary resuscitation (CPR) and first aid for 1 of 2 sampled caregivers (Employee #2). Findings include: Employee #2 Employee #2 was hired as a Caregiver on 03/27/08. The employee's file contained a first aid and CPR training certificate with an expiration date of 01/21/21, however, the CPR and first aid training were not renewed until 03/24/21. On 08/06/21 at 10:45 AM, the Administrator and Caregiver confirmed the lapse in CPR and first aid training and further explained the employee was providing care to the residents during the lapse in the first aid training. Severity: 2 Scope: 1	ID PREFIX TAG 0106	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 08/10/202 1

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(X4) ID PREFIX TAG 0870 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0870	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 08/10/202 1
	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on document review, record review and interview, the Administrator failed to ensure a medication profile review was performed by a physician, a pharmacist or a registered nurse at least once every six months for 1 of 5 sampled residents residing in the facility for longer than six months (Resident #5). Findings include: Resident # 5 Resident #5 was admitted to the facility on 12/30/20, with diagnoses including dementia and hypertension. Resident #5's medical record lacked documented evidence a six-month pharmacy review had been conducted. On 08/06/21 at 10:03 AM, the Administrator confirmed the medication review for Resident #5 had not been completed on time. Severity: 2 Scope: 1			

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(X4) ID PREFIX TAG 0960 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0960	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 08/10/2021
	Alzheimer's Care Application for Endorsement - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer ' s disease. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain an Alzheimer's endorsement to provide care to residents with Alzheimer's Disease or related dementia for 1 of 5 residents (Resident #5). Findings include: Resident # 5 Resident #5 was admitted to the facility on 12/30/20, with diagnoses including dementia and hypertension. Resident #5's medical record lacked documented evidence of a Physician Placement Determination form. On 08/06/21 in the morning, Resident #5 was not available to conduct a mini cognitive assessment. On 08/06/21 at 10:03 AM, the Administrator confirmed the facility did not obtain an Alzheimer's endorsement to care for Resident #5 with Alzheimer's/dementia. Severity: 2 Scope: 1			