STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7210	A. BUILDING _____ B. WING _____	06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY HEIGHTS RESIDENTIAL CARE, LLC	210 SOUTH ORMSBY BLVD, CARSON CITY, NEVADA ,89703

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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 06/08/20. 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 10 Residential Facility for Group beds for elderly and disabled persons, five Category I and five Category II residents. The census at the time of the survey was 10. Ten resident files and nine 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, action, 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		
0272 SS= F	Service of Food - Menus - NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. Inspector Comments: Based on observation, record review, and interview, the facility failed to prepare menus one week in advance, post lunch menus, and keep lunch menus on file for 90 days. Findings include: On 06/08/20 during a tour of the facility, breakfast and dinner menus were posted on the refrigerator in the kitchen for 06/01/20 through 06/08/20. However, no lunch menus were posted for any days in June 2020, and no breakfast and dinner menus were posted for the rest of the days of the current week - 06/09/20, 06/10/20, 06/11/20, 06/12/20, and 06/13/20. On 06/08/20 at 12:10 PM, residents were observed eating lunch. A Medication Technician/Caregiver (MT/C) verified no menu was posted for the day's lunch. The reason was the staff asked residents each day what they would like to eat for lunch and then prepared what the residents requested. The MT/C verbalized one	0272	1) Lunch menus have been made. 2) Lunch menus will now be made in advance along with the breakfast an dinner menus. 3) Lunch menus have been added to the list of monthly postings and will be done along with breakfast and dinner menus. 4) Employee #2 is responsible for completing this task. 5) Correction was made om 6/10/2020. 6) see attachment 7) Item has been added to list of monthly tasks	06/10/2020

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	resident had requested pancakes for lunch while the rest of the residents had asked for chicken fingers. Residents had been served what they had requested for lunch on 06/08/20. On 06/08/20 at 12:16 PM, the Manager verbalized general practice was to prepare breakfast and dinner menus one month in advance. The Manager expressed this task had not been accomplished in June 2020 and could have been delegated. A review of meal menus and snacks provided from December 2019 through June 2020 revealed no menus for lunches served had been kept on file. On 06/08/20 after 1:30 PM, the Manager explained the facility's practice was for staff to ask residents what they wanted to eat for lunch every day. Therefore, no lunch menus were written one week in advance or at all. The Manager verbalized the facility had a variety of food available each week coinciding with resident preferences. However, the Manager admitted on rare occasions the facility might not have had exactly what a resident requested for lunch. Severity: 2 Scope: 3			

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to obtain a physical examination prior to the admission of 1 of 10 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 12/02/19 with diagnoses including hospice and need for continuous oxygen. Resident #6's medical record lacked evidence a physical examination with a review of systems was completed by a physician prior to admission. The record contained a document titled "Updated Hospice Plan of Care/Comprehensive Assessment," dated before 12/02/19 and it did not include a review of systems. On 06/08/20 before 12:00 PM, the Manager verbalized Resident #6 had been on hospice prior to being admitted to the facility and continued with the same hospice service after admission to the facility. The Manager believed the updated hospice plan of care/comprehensive assessment document was the same as the results of a physical examination. The Manager verified the document did not include a review of systems. Severity: 2 Scope: 1	0859	1) Document was faxed to facility by hospice on date of survey. 2) Ensure that what we believe to be acceptable physicals have review of systems. 3) Documentation of physical examination will be reviewed for review of systems upon resident admission. 4) Employee #2 will be responsible. 5) 6/8/2020 6) see attached 7) Documentation will be reviewed upon resident admission.	06/08/2020
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication	0895	1) Resident #8, hospice faxed new order to facility and pharmacy on 6/8/2020. Pharmacy corrected directions on MAR. Resident #9, Caregiver error corrected on MAR on 6/8/2020. 2) Facility will have two staff members check for accuracy of how orders are written on MAR. 3) Employee #2 will monitor for accuracy. 4) Employee #2 will be responsible.	06/10/2020

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	administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure 1) a physician's order for over-the-counter medication was transcribed correctly onto the Medical Administration Record (MAR) for 1 of 10 residents (Resident #8) and 2) as needed medication for 1 of 10 residents (Resident #9) was properly documented on the MAR. Findings include: Resident #8 Resident #8 was admitted to the facility on 09/11/15 with diagnoses including cerebral infarction, senile degeneration of the brain, and hypertension. Resident #8's June 2020 MAR documented Coricidin HBP Cough & Cold, dissolve 1 cough drop by mouth every 4 hours as needed for cough or congestion. May give additional dose at 10 PM and 2 AM if patient coughs during sleep. The resident's medical record included an edited medication order from the hospice physician, dated 02/03/20, for Coricidin HBP/Cough - (Expectorant/Cough Suppressant) documenting 10/200 milligram tab. Give one tablet - by mouth - 6 AM, 10 AM, 2 PM, 6 PM ---Cough/Congestion - May give additional dose of one tablet at 10 PM and 2 AM if patient coughing during sleep. On 06/08/20 at 5:10 PM, the Manager verbalized Resident #8's MAR had not been updated with the most recent physician's order for Coricidin HBP. Resident #9 Resident #9 was admitted to the facility on 06/01/20 with diagnoses including type II diabetes, chronic pulmonary embolism, and major depressive disorder. Resident #9's June 2020 MAR documented hydroxyzine pamoate 25 milligram, give one capsule by mouth three times daily for itching as needed. The Caregiver initialed administering this medication to the resident in the space for 06/07/20. However, the Caregiver documented on the back of the MAR the		5) 6/10/2020	

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	medication administration, reason for it, and result of it as being completed on 06/08/20. On 06/08/20 at 5:00 PM, the Caregiver verbalized the as needed medication was administered on 06/08/20, as documented on the back of the MAR, and the Caregiver had initialed the 06/07/20 box in error. Severity: 2 Scope: 1			
0936 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 residents met the requirements concerning tuberculosis (TB) testing (Resident #9 and Resident #10). Findings include: Resident #9 Resident #9 was admitted to the facility on 06/01/20 with diagnoses including type II diabetes, chronic pulmonary embolism, major depressive disorder. Resident #9's medical record included an annual one-step TB test administered on 02/12/20 and read on 02/15/20. The result of the test was not documented. Resident #9's medical record included a 2-Step TB test, with the first step administered on 06/11/19 and the second step administered on 06/18/19. Both steps were marked as being negative. However, no read dates were documented. On 06/08/20 at 5:10 PM, the Manager verbalized Resident #9's medical record was incomplete because it lacked a result for the one-step TB test in 2020 and read dates for the 2-Step TB test in 2019. Resident #10 Resident #10 was admitted to the facility on 06/02/20 with diagnoses	0936	1) Documentation was corrected by referring facilities. 2) Documentation will be reviewed for completion upon resident admission. 3) Documentation will be reviewed for completion upon resident admission. 4) Employee #2 5) 6/10/2020	06/10/2020

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	including lung cancer, congestive obstructive pulmonary disease, hypertension, and type II diabetes. Resident #10's medical record included a two-step TB test. The first step was administered on 05/18/19 and marked as negative. However, no read date was documented. The second step was administered on 06/02/20 and read as negative on 06/05/20. On 06/08/20 at 5:10 PM, the Manager confirmed the documentation of the first step of Resident #10's TB test lacked a read date. The Manager verbalized it was important for facility staff to ensure accuracy of residents' TB test documentation going forward. Severity: 2 Scope: 1			