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
	7210	A. BUILDING ____________________ B. WING ______________________	11/19/2020

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

(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 State Licensure COVID-19 Infection Control and Prevention Plan Survey conducted in your facility on 11/19/20. 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 was licensed for 10 Residential Facility for Group beds for elderly and disabled persons, 5 Category I and 5 Category II residents. The census at the time of the survey was eight. A resident who experienced symptoms of respiratory illness had been admitted to the hospital; COVID-19 test results were pending at the time of the survey. There were no residents or staff with the virus in the facility at the time of the survey. The facility utilized the front entrance as the main access. All staff and essential healthcare workers were required to complete a written questionnaire for COVID-19 signs and symptoms, have their temperature taken, wear a facial mask, and use hand sanitizer before entering. There was documented evidence the residents were screened for symptoms of COVID-19, including temperature checks, daily. All residents maintained social distancing while in the dining and common areas. Staff wore surgical masks at all times and gloves while providing resident care. Staff reminded residents, as needed, to social distance in the common areas and wash their hands frequently. An interview with a caregiver revealed the facility had an adequate supply of personal protective equipment, which included disposable gowns, gloves, face shields, goggles, surgical masks, and N95 respirator masks (N95). There was documented evidence five facility staff members had completed N95 fit testing. Staff verbalized cleaning daily with bleach products to disinfect surfaces. Staff received continuing education on Infection Prevention and Control through weekly meetings that included frequently updated guidelines from the Centers for Disease Control and Prevention. A review of the facility's	0000		

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 REPRESENTATIVE'S SIGNATURE	Name:	Title:	Date:

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	Infection Control and Prevention Plan revealed the facility had the following components documented and ready for implementation: - 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 N95 masks; - Respirator Program; - Identification and response to residents with suspected or confirmed COVID-19; - New Admissions or Readmissions with an unknown COVID-19 status; and - Required notifications. During an interview, the Administrator described implementation of the plan. 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.			