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 |
|---|---|---|---|
| | 8650 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOTHER'S TOUCH SENIOR HOME | 8918 KING JOHN COURT, LAS VEGAS, NEVADA ,89149 |

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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a FOCUSED COVID-19 infection control survey conducted at your facility on 05/14/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was four. All residents and staff were tested for COVID-19. Three of four residents were tested positive for COVID-19, and isolated in their bedroom units. One employee tested positive for COVID-19, and in isolation in a casita outside of the main property. The investigation of regulatory compliance of Infection Control and Prevention included: Observations: - No temperature check was conducted, and COVID-19 screening questions were not asked prior to the inspector entering the facility. (See TAG 0050) - The Administrator/sole caregiver applied a cloth mask over the nose and mouth area after allowing the inspector to the facility. - The Administrator/sole caregiver immediately washed their hands upon allowing the inspector to the facility. - The Administrator/sole caregiver donned a gown midway through the infection control inspection Interview: - The Administrator/sole caregiver reported common touched surfaces are cleaned throughout the day. The facility failed to have an Infection Control Policy. (See TAG 0050) Interview with the Administrator/Caregiver revealed that the facility did not have any new face masks available. The Administrator verbalized that new face masks had been ordered and was awaiting delivery. 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, actions or other claims for relief that may be available to any party under applicable federal, state, | 0000 | | |

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| | or local laws. The following deficiencies were identified: | | | |
| 0050 SS= F | Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS.<br><br>Inspector Comments: Based on interview and observation, the Administrator did not ensure a visitor of the facility was screened for COVID-19 according to CDC guidelines prior to entry to the facility. Findings include: On 05/14/20 at approximately 8:45 AM, The Administrator/Caregiver did not take the temperature or ask COVID-19 screening questions of the health facilities inspector prior to entry to the facility. The Administrator verbalized that previously caregivers conducted temperature checks and asked COVID-19 infection control screening questions to all visitors prior to entry to the facility. On 05/14/20 at approximately 9:45 AM, The Administrator/Caregiver reported the facility lacked an infection control policy. Severity: 2 Scope: 3 | 0050 | Attached, please find the COVID-19 questionnaire of anyone wanting to visit the facility, as well as the Infection Control Policy and Procedure for COVID-19.<br>Truth is, I had just finished with cleaning the residents, showered, and was still getting myself ready when the doorbell rang around 8:30am. There has been no visitor other than the Hospice RN since around mid-March as I put the facility on lock-down. I was expecting a package delivery which is usually left at the door after the bell is rung. I was literally standing by my cloth mask and gloves to don them, when the bell rang. No excuses, but next time going forward, I will always put on my mask, gloves, and blue gown(I have one blue one now) prior to answering the door. Moving forward, visitor's temperature will be taken as well as have them answer and sign the COVID-19 QUESTIONNAIRE, prior to entering the facility. Then they will proceed straight to the bathroom and wash their hands, and they must be wearing a mask when they ring the bell. I normally have my mask, gloves, and torn thin yellow gown with a kitchen apron over it on, before doing chores for the resident, cook, or clean. Moving forward, the Administrator or any staff will have all the required PPE's on at all times while in the facility and doing work. Staff has been trained on the Infection Control Policy and understands it. They have been wearing the required PPE's since the visit 5/14/2020. Administrator will constantly monitor to make sure they wash their hands often as well as wear their PPE's while on duty. The Administrator or the designated Staff will ensure proper PPE's and Infection Control Policy and Procedure is adhered to. | 05/14/2020 |
| 0992 SS= F | Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall | 0992 | We discovered on 4/22/20 that a resident who went to the hospital on 4/19/20 for Bp issues tested positive. She continued to be Asymptomatic throughout her stay at the hospital and when cleared moved to another facility as I would not take her back. The same day, the Administrator with concern for the welfare of the other | 05/22/2020 |

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| | ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768.<br><br>Inspector Comments: Based on observation and interview, the facility did not ensure a staff member was awake at night while residents slept. Findings include: On 05/14/20 at approximately 9:30 AM , the Administrator indicated the facility had two employees. One employee arrives to the facility at approximately 6:00 PM each night to clean for approximately an hour; and the Administrator was the only other employee. The Administrator admitted she sleeps about three hours a night on the couch. The Administrator revealed three employees recently resigned, and another employee tested positive for COVID-19 on 04/27/20. The COVID-19 positive employee is in isolation in a separate building on the property. The Administrator indicated she was actively recruiting new caregivers. Severity: 2 Scope: 3 | | residents and staff called all over to get a lab to come out and test everyone, out of pocket at $160/head. Results came in on 4/29 with with one staff positive (still Asymptomatic) and a resident. Those staff who tested negative wanted their salary on the spot and left saying they will return when all is negative in the facility. The staff with the positive was asked to stay in one of the Casita rooms and quarantine herself. As I was now the only caregiver, and luckily a very light sleeper, I took over caring for all the residents, cooking, and cleaning. Beginning of May, I found a former staff who had all her PPE gear, and offered to come in and disinfect and clean for 3 hours each evening. She comes in before 6pm and leaves at 9pm. The disinfecting and sanitizing of the whole house usually takes her maybe and hour to an hour and a half, as I informed the Inspector. While she is there, I give her small chores to do, like wipe the blinds, fold laundry, etc. As I told HCQC since the first report I made, I informed them that I was working alone as I could not get anyone to work while there was someone with positive COVID-19 in the house. Before this, my ratio was 2.5 resident to1 Staff day shift, more than what the State requires, as well as had a stay awake staff. The fact that I was alone was not by choice but by circumstances. As I mentioned several times to HCQC officials, it's a good thing I sleep very little, usually a good night for me is about 3 hours at home. That time, at the facility, I took a short nap, sometimes, half an hour, sometimes an hour, and if no one rings their buzzer for me to pick up their remote or adjust their pillow or pick up the trash they threw on the floor, I got about 2 hours at night on the couch. I checked on everyone throughout the night and I was wide awake after a short nap. Residents were well, kept happy, very clean, no redness anywhere, and very well fed. Only complaint was that I gave them too much to eat. I am very happy to report that I have found two staff who are negative and willing to work; one for day shift, and one for night shift and each wanting to work 6 days or 6 nights a week. I cover for their off day or nights, alternating so there is a break between the night and day shift for | |

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| | | | me. Night shift staff started on the night of 5/22/2020, and day shift staff started on Tuesday 5/26/2020. I make sure they wear their mask, gloves, shield (when caring for resident), and blue gown the entire time they are on duty. The night shift also wears a head cover and double face mask. Going forward, the Administrator or the designated staff will ensure that there will always be a stay awake staff on duty. The whole experience for almost a month an a half was very humbling and very difficult during the first couple of days, then I got more efficient and it became easy. I paid to have many potential staff tested and all were negative, but now I have only 3 residents, so I cannot hire them yet. I am there daily to check on things and assist the staff. One resident that was positive was sent to the hospital for bleeding from her vaginal area like someone having a period. Her daughter's wanted her taken by 311 to get that checked. She will stay there until she is negative for COVID, then move to Illinois with them, as no one is in Vegas. Moving forward, the Administrator or the designated staff will ensure, a stay awake staff is on duty. | |