STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8827	A. BUILDING _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH & HOPE HOME CARE, LLC	**973 LEPORI WAY, SPARKS, NEVADA ,89431-1165**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey conducted in your facility on 08/13/2024, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was four. Five resident files and four employee files were reviewed. The facility received a grade of B. 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, or local laws. The following deficiencies were identified:	0000		
0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure all windows capable of being opened in the facility to provide ventilation for the facility were screened to prevent the entry of insects. Findings include: On 08/13/2024 at 10:25 AM, one window outside private bedroom #2 lacked a screen. On 08/13/2024 at 10:26 AM, a Caregiver confirmed the window for private bedroom #2 lacked a screen. On 08/13/2024 at 2:39 PM, the Owner confirmed the missing screen for the window of private bedroom #2. The Owner did not know why the screen was missing. Severity: 2 Scope: 1	0179	The screen for the window bedroom #2 lacked a screen on 8/13/24. This was corrected the same day 8/13/24 & I emailed a picture of that to our surveyor. It was not put back to the window because they took it out to clean the dust. We understand the importance of having the screen in all windows that are capable of being opened in the facility and all the doors must be screen to prevent entry of insects. Management, staff and housekeeping is now aware and will make sure that this will not happen again.	08/13/2024

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0252 SS= D	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation and interview, the facility failed to ensure food in the freezer was stored appropriately. Findings include: On 08/13/2024 at 10:32 AM, located in the freezer were the following items: -one bag of frozen mixed vegetables, 32 ounces (oz) -one bag of frozen corn, 2 pounds (lbs) -one bag of frozen El Monterey Chimichanga cook and serve, 3.8 lbs -one bag of frozen crinkle cut french fries, 5 lbs -one box of frozen Texas Garlic Toast, 8 slices, 11.25 oz -one bag of frozen tater tots, 5 lbs -one bag Armour Italian Style Meatballs, 14 oz. All of the items were opened and unsealed original packaging. On 08/13/2024 at 10:34 AM, the Caregiver explained the frozen food would not stay fresh if the opened bags or boxes were not sealed. The Caregiver confirmed the frozen items were not in a sealed bag or container and the food was for the residents. On 08/13/2024 at 10:37 AM, the Owner explained a consequence of storing frozen food items in the original opened packages and not providing sealed packaging could cause the food to become contaminated and would not be fresh. The Owner confirmed the frozen items were not stored properly. Severity: 2 Scope: 1	0252	Management and staff was updated about proper and adequate storage and packaging on 8/14/24. The food mentioned: one bag of frozen mixed veggies, one bag of frozen corn, one bag of frozen El Monterey Chimichanga cook and serve, one bag of frozen crinkle cut french fries, one box of frozen texas garlic toast, one bag of frozen totes, bag of amour italian style meatballs, all of the items are now properly wrapped and sealed in ziploc bag/seran wrapp with proper label, like the date it was opened, and the date it is going to expire. Management re trained staff on how to properly store food and explained the importance of keeping food fresh and sealed to keep it from being contaminated. The training and updating information was done on 8/15/24	08/14/2024

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0451 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure the contents of a first aid kit were not expired. Findings include: On 08/13/2024, a review of the facility's first aid kit located in the front foyer contained the following expired items: -four, 0.5 gram packets of Triple Antibiotic Ointment, expired on 02/2023. -one packet of Non-Aspirin containing two 325 milligrams (mg) tablets, expired on 11/2021. On 08/13/2024 at 10:39 AM, the Owner confirmed the Triple Antibiotic Ointment and the Non-Aspirin 325 mg tablets in the first aid kit were expired. The Owner explained the items would not work as intended if used after the items had expired. Severity: 2 Scope: 1	0451	The First Aid kit have been replaced with a brand new pack on 8/14/24 and have an expiration date of 6/2028. New First aid Kit includes the following: Thermometer, CPR mask, Disposable gloves, rolls of guaze , adhesive tape and bandages, Sterile guaze, Germicide, different sizes of bandages. Management also make sure to refill and check the first aid kit every 6 months to avoid expiration dates and to make sure that it is always ready and open for emergency.	08/14/2024
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 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 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; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be	0895	The MAR have been corrected on 8/14/24 and we will continue to be more pro active and to have someone double check the transcribing of new orders. Management and staff with medication management training had a meeting and planned to improve and how to avoid human mistakes during transcribing new orders. Two staff will make sure that the monthly MAR that is printed will be corrected and double checked my two individuals before printing it for the new month. The Dextromethorpahn-Guaifenesin (Tussin DM) 10-100 milligrams (mg)/5 ml. Is now matched with the original order and what is on the Mar and the label on the Medicine itself. Take 10 ml by mouth every six hours as needed for cough. The Fiber powder is now corrected. The error was an honest mistake . it was a	08/14/2024

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	administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on observation, interview and clinical record review, the facility failed to ensure a Medication Administration Record (MAR) accurately reflected the correct frequency to administer medication to a resident for 1 of 5 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 09/06/2022, with diagnoses including major depressive disorder, chronic, type II diabetes mellitus, and bipolar disorder. A physician's order dated 09/18/2023, documented Dextromethorphan-Guaifenesin (Tussin DM) 10-100 milligrams (mg)/5 milliliters (ml).Take 10 ml by mouth every six hours as needed for cough. A physician's order dated 12/18/2023, documented Metamucil 28.3 percent oral powder. Take one scoop by mouth every day. Dissolve in 6 ounces of fluid. Resident #3's Medication Administration Record (MAR) for August 2024, documented the following: -Cough DM 10-100 mg/5 ml. Take 10 ml by mouth as needed for cough, order date 09/18/2023. -Fiber Powder. Mix one scoop of powder into 6 ounces of liquid on drink, order date 12/18/2022. On 08/13/2024 at 2:32 PM, during review of Resident #3's medications, the Owner confirmed the frequency of the available medications were not accurately transcribed from the physician orders to the resident's MAR. The Owner explained Resident #3 could experience an overdose or not be administered a medication in a timely manner to provide relief because of the error in transcription. The Owner explained the medication administration times should have been included on the MAR. On 08/13/2024, in the afternoon, Resident #3's pharmacy confirmed the Fiber Powder order was written on 12/18/2023, and the MAR		"typo" on the mar the Fiber Powder order was transcribed as 12/18/2025 instead of the correct one that is 12/18.2023. All of the deficiency mentioned has already been updated on (8/14/24) , it was double checked and now transcribed accurately on the MAR. Management and staff starting now and the future will ensure the accurate transcribing by having two staff check on each other before printing the MAR. Management and Staff with Medication Management Cert understand that importance and severity and adverse effect on medication management errors.	

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	had been transcribed incorrectly as there was no other order for the medication in the resident's records. On 08/13/2024 at 2:37 PM, the Owner confirmed the Owner transcribed all orders to the resident MARs. The Owner explained the orders for Resident #3's Cough DM and Fiber Powder were not transcribed correctly to include the frequency of the medication administration and were not correct. The Owner confirmed the Fiber Powder order was incorrectly transcribed to the MAR with the wrong year. The facility policy titled "The Medication Plan," undated, documented the facility would provide verification the medication orders had been accurately transcribed onto the MAR. The Manager was responsible for transcribing medication orders onto the MAR each month and anytime there was a change to the resident's medications. Severity: 2 Scope: 1			
1600 SS= C	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or	1600	This has been corrected and completed on 8/26/24. All form of the facility will now include and address the preferred name, and pronoun and in accordance with his or he gender identity or sexual expression. Our staff have been trained on and certified on cultural competency. All forms are updated, and current residents in the facility has been updated and is given the opportunity to fill out the form and is now on their chart. Our Facility has updated and added policies according to cultural competency, there is already a chart made just for the policies to address the preferred name, in accordance to his or her gender identity. Our facility will ensure that this will be followed and will be given to the future residents as well.	08/26/2024

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	resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure there were policies developed and resident records records were adapted to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 3 of 5 sampled residents (Residents #1, #2, and #4). Findings include: Resident #1 was admitted to the facility on 05/07/2024, with diagnoses including tachycardia,			

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	paroxysmal, hypertension, and major depressive disorder. Resident #2 was admitted to the facility on 04/29/2024, with diagnoses including depression and anxiety. Resident #4 was admitted to the facility on 6/10/2024, with a diagnosis of seizure disorder. On 08/13/2024, in the morning, three sampled resident clinical records were reviewed. The facility records for Resident #1, #2, and #4, lacked of compliance. On 08/13/2024 at 10:58 AM, the Owner confirmed the facility had not made any changes to resident clinical records or the Cultural Compliance Policy to obtain regulatory compliance. Severity: 1 Scope: 3			