DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**09/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, RENO, NEVADA ,89509**

(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 a complaint investigation completed in your facility on 09/28/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 27. The sample size was five. One complaint was investigated. Complaint #NV00064796 with the following allegation could not be substantiated. Allegation #1, the Administrator threatened eviction of a resident due to their bad personality could not be substantiated based on lack of evidence. The investigation into the allegation included: Interviews were conducted with the Owner, Administrator, and residents. Review of staff training. Allegation #2, a resident was called fat by staff could not be substantiated based on lack of evidence. The investigation into the allegation included: Interviews were conducted with the Owner, Administrator, and residents. Observation of staff interaction with residents. Review of staff training. Allegation #3, staff handled residents too roughly and left bruises could not be substantiated based on lack of evidence. The investigation into the allegation included: Interviews were conducted with the Owner, Administrator, and residents. Review of staff training. Review of resident incident reports. Allegation #4, a resident was put to bed right after dinner and not allowed to stay up and watch television could not be substantiated based on lack of evidence. The investigation into the allegations included: Interviews were conducted with the Owner, Administrator, and residents. Review of staff training. Review of policies. Review of Admission Agreement. Allegation #5, the Owner did not wear a mask in the facility was substantiated (see Tag Y593). Allegation #6, offensive odor was in the facility due to wildfire smoke could not be	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SCOTT REDDY Title: Administrator Date: 10/16/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	substantiated based on lack of evidence. The investigation into the allegations included: Interviews were conducted with the Owner, Administrator, and residents. The facility was toured. Allegation #7, a resident was forced to wait too long for toileting assistance could not be substantiated based on lack of evidence. The investigation into the allegations included: Interviews were conducted with the Owner, Administrator, and residents. 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:			

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0524 SS= D	449.259(3)(a) - Supervision of Residents - NAC 449.259 Supervision and treatment of residents generally. 3. The employees of a residential facility shall: (a) Treat each resident in a kind an considerate manner. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident received considerate and respectful care by ensuring a resident could sleep without interruption for 1 of 5 residents (Resident #1). Findings include: Resident #1 was admitted to the facility on 06/09/21 with diagnoses including diabetes mellitus, dementia, hypertension, and chronic obstructive pulmonary disease. On 09/27/21 at 10:46 AM, Resident #1 verbalized a small child had been running through the facility at night. Due to the noise made by the child, Resident #1 was unable to sleep. On 09/27/21 at exit, the owner verbalized a Caregiver brings their child to work because the Caregiver's spouse works away from home. The only way the Caregiver can work was to bring the child. Severity: 2 Scope: 1	0524	The findings of the Surveyor are probably correct. The child in question, normally sat in the area adjacent to the downstairs office playing video games or sleeping. Normally, the father of the child came by the facility when he finished his shift as a truckdriver and picked up the child to take him home. On this occasion, the husband needed to work late and was not able to pick up the child at the normal time. The child in question had special needs that made the child have difficulties controlling the volume of his voice. It is very likely that the child did make loud noises and because resident #1 probably chooses to keep his room door open at night, as most of our residents do, the resident was disturbed. This was the only employee who brought a young child to work, and this employee has voluntarily chosen to work elsewhere for reasons not related to this incident; she no longer works in our facility. I do not anticipate having a similar problem in the future. Permission to allow children to stay in our facility will be given on a case-by-case basis. Children who are not able or willing to control their behavior may not be allowed to remain in the facility. The Administrator will be responsible for this corrective action. The policy change is effective immediately.	10/16/2021

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0593 SS= E	449.268(1)(d) - Resident Rights - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment. Inspector Comments: Based on observation and interview, the facility failed to maintain an environment to promote the safety of the residents and stop the spread of Covid-19. This practice affected all residents, staff, and visiting health providers. Findings include: On 09/27/21 at 10:29 AM, a State surveyor entered the facility. Upon entrance, a staff member went upstairs to retrieve the Owner. When the Owner came downstairs, they were not wearing a mask. The Owner took the surveyor upstairs to the business office. No mask was worn by the Owner until the the Owner was questioned about the lack of a mask. On 09/27/21 at exit, the Owner verbalized a mask was not worn when in the office. The Owner also verbalized when the surveyor entered the facility, being surprised and forgetting to put a mask on. The facility's "Infection Prevention and Control Plan," 2020, stated "Cover your mouth and nose with a mask when around others." Severity: 2 Scope: 3	0593	The findings of the surveyor are correct. The owner is very sorry that she forgot to wear her mask. The owner of the facility is in the habit of not wearing her mask when she is working by herself in her office and she forgot to put a mask on when she went to greet the surveyor. A sign that says, "**PLEASE PUT YOUR MASK ON!**" has been placed next to the office door to help remind anyone in the office to put on a mask before exiting. This corrective action has already been completed. The administrator was responsible for completion of this task.	10/16/2021