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
	9415	A. BUILDING _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HEART GROUP HOME CARE I	3413 ALPAND LANE, SPARKS, NEVADA ,89434

(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 an annual State Licensure survey conducted in your facility on 08/30/23. 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 ten residential facility for group beds for elderly or disabled persons, and/or persons with mental illness and/or persons with chronic illness, Category II residents. The census at the time of the survey was ten. Ten resident files and four 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, actions 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		
1810 SS= F	Infection Control Program Inspector Comments: Based on document review and interview, the facility failed to develop an infection control program and corresponding policies to prevent and control infections within the facility potentially affecting 10 of 10 residents. Findings include: On 08/30/23, the facility lacked an infection control program and did not have infection control policies in place to ensure the safety needs of residents, staff, and visitors. On 08/30/23 at 12:04 PM, the Administrator was not able to produce any documentation of an infection control program addressing the current guidelines for infection control within the facility. Severity: 2 Scope: 3	1810	According to the findings regarding infection control training, the administrator failed to provide policies and procedure regarding infection control. The Administrator will make sure to develop an infection control program, policies and procedure to be followed any the staff members to to ensure the safety needs of residents, staff, and visitors. Policies and procedures should remade available in a month time. Training should be provided to each employee and the administrator and/or the manager will make sure that it is being followed and implemented.	10/11/2023

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: PURITA RAMIREZ Title: ADMINISTRATOR Date: 09/11/2023

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1815 SS= F	Emergency Preparedness Plan Inspector Comments: Based on interview and document review, the facility failed to develop an emergency preparedness plan potentially affecting 10 of 10 residents. Findings include: On 08/30/23, the facility lacked documented evidence of a written emergency preparedness plan at the time of the annual survey. On 08/30/23 at 12:04 PM, the Administrator confirmed the facility did not have a written emergency preparedness plan. Severity: 2 Scope: 3	1815	Based on interview and document review during the survey, the facility failed to develop an emergency preparedness plan which could potentially affect the residents and employees of the facility. lacked documented evidence of a written emergency preparedness plan. The administrator will prepare and to provide policies and procedure regarding emergency preparedness plan to be followed any the staff members to to ensure the safety needs of residents, staff, and visitors. Policies and procedures should remade available in 3 months time. Training regarding emergency preparedness should be provided to each employee and the administrator and/or the manager will make sure that it is being followed and implemented during emergency situations.	12/11/2023
1830 SS= F	Infection Control Required Training Inspector Comments: Based on personnel file review, document review, and interview, the primary and secondary infection control person lacked the required infection control training potentially affecting 10 of 10 residents. Findings include: On 08/30/23 at 12:00 PM, the personnel files for the Administrator and Caregiver, the primary and secondary infection control person, respectively, lacked documented evidence of 15 hours of training concerning the control and prevention of infectious disease from the approved nationally recognized organizations. On 08/30/23 at 12:04 PM, the Administrator confirmed the required infection control and prevention training had not been completed. Severity: 2 Scope: 3	1830	During the survey, the facility was not able to provide certification on infection control of the primary and secondary person. The administrator and/or manager will acquire training within 30 days and make sure that 15 units training hours will be completed by the primary and secondary person on the infection control annually.	10/11/2023