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
	9431	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS CASTLE HOME OF FERNLEY	**575 FARM DISTRICT ROAD, FERNLEY, NEVADA ,89408**

(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 follow-up State Licensure COVID-19 Infection Control and Prevention Plan Survey conducted in your facility on 08/21/20. 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 is licensed for 16 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 15. There were no positive or presumptive Covid-19 residents or staff that the time of the survey. The five positive residents have been on quarantine for fifteen days and were not retested for Covid-19. The facility utilized the front entrance as the main access point. All staff members and essential visitors were required to complete a questionnaire for COVID-19 signs and symptoms, have their temperature taken and were instructed to wear a surgical mask. Signage on the front door documented "This is a sealed entrance-Do Not Enter." The facility was not allowing any healthcare providers to see the residents in person and were utilizing telemedicine. Observed incontinence supplies dropped off at the front door for a hospice resident. Observed staff to wear masks and gloves with all resident care. All residents were observed to be socially distanced in the dining area. The common area had reclining chairs spaced six feet apart to promote social distancing for the residents. Interviews conducted with the Manager revealed the facility maintained an adequate supply of the following personal protective equipment: disposable gowns, gloves, surgical masks, and N95 masks. The facility provided continuing education on Infection Prevention and Control Training to staff members through weekly huddles and review of Centers for Disease Control guidelines. A review of the facility's Infection Control and Prevention Plan revealed the facility had the following components documented and ready for	0000		

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	implementation: -A verbal interview with Manager describing implementation of the plan. -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 N-95 masks -Respirator Program -Identification and response to residents with suspected or confirmed COVID-19 -New Admissions or Readmissions with an unknown COVID-19 status -Required notifications 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.			