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 _____	**01/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HOME CARE RHL	**975 CORDONE AVENUE, RENO, NEVADA ,89502**

(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 initiated at your facility on 01/31/22. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, and/or persons with chronic illness, Category II residents. The census at the time of investigation was nine. The sample size was nine. Complaint #NV00065620 with an allegation a resident had eloped from the facility was substantiated (See Tag Y0515). 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiency was identified:	0000		
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on record review, interview and document review, the facility failed to provide protective supervision for 1 of 9 sampled residents (Resident #1) resulting in an elopement from the facility. Findings include: Resident #1 Resident #1 was admitted to the facility on 02/08/21, with diagnoses including schizoaffective disorder and insomnia. A History and Physical dated 02/08/21, documented Resident #1 there was a concern for undiagnosed dementia after	0515	(A) 0515 1. Resident #1 was admitted in the group home 02/0821 2. Resident #1 loves to walk and do outside walk around with supervision, but we notice that she can still remember her house 3. Resident went missing last 01-19-22 , we drove around and could not find her , so we reported the incident to the police 4. The police found the resident and the resident explain to the police and to us that she went walking to go to the house of her daughter because she wanted to see her grand kid. The direction she was located by the police is close to the resident of her daughter. 5. Resident # 1 walk out and did not ask permission because she said that she will not be permitted to go out. but we explain to the	04/06/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: FLORENTINO LEANILLO | Title: Administrator | Date: 04/06/2022

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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	Resident #1 had walked away from their daughter's home. The resident was only alert and oriented to self. On 01/31/22 at 9:56 AM, the Caregiver explained on 01/19/22, Resident #1 had disappeared from the facility. There was a resident who always went out in front of the facility multiple times a day and upon entering the facility, was to lock the door. This particular day, the resident did not lock the door and Resident #1 left the facility while the Caregiver was in the back of the house doing laundry. Resident #1 was not discovered missing for approximately two hours. The resident had left the facility around 1:30 PM. Once the Caregiver realized Resident #1 was not present in the facility, the Caregiver walked up and down the street, however did not locate Resident #1. The Caregiver called the Owner who then called 9-1-1. The responding police officers located the resident near a casino, approximately three blocks away from the facility, and returned the resident to the facility at 7:00 PM. The Caregiver verbalized no alarms were on any of the doors leading outside and the door was left unlocked, resulting in Resident #1 eloping from the facility. The Caregiver explained Resident #1 had memory problems and had no idea where they were going. The Caregiver verbalized they were the only caregiver on duty in the facility and was usually left to supervise the residents on shift by themselves. The Nevada Division of Health Care Finance and Policy (DHCFP) Serious Occurrence Report dated 01/19/22, documented Resident #1 had left the facility at approximately 1:00 PM on 01/19/22. The Caregiver attempted to look for the resident upon discovering the resident missing. The police department was called and officers were able to locate the resident near a casino and bring the resident back to the facility. Complaint# NV00065620 Severity: 2 Scope: 1		resident # that to ask permission to the caregiver and that we will drive her to her to visit her family (B) 1. There are always 2 caregiver in the facility , but the day resident 1 left un notice one of the caregiver went out to buys something at the store 2. The facility installed alarm on the front door 3. All caregiver are given a memo / reminder to always keep an eye on all the resident all the time 4. Resident # 1 has no diagnosis of Alzheimer see attachments (attachment 1 door alarm and attachment 2, current physician placement determination) 5. The facility requested the primary physician to do a new assessments to resident #1 to be sure that she can live in this facility (C) 0515 plan of care 1. The facility installed an alarm on the front of the door (see attachment) 2. The two caregiver are assigned to alternate , to check on all the resident all the time to be sure that nobody will go out with out permission 3. Always check all the door and check the alarm if its working all the time 4. Talk to the resident if they have any problem regarding going out of the facility, that the owner can help locate or visit relatives if necessary. 5. The caregiver, administrator of this facility will ensure that this problem will not happen again 6. The caregiver and the administrator of this facility will observe and report to the primary doctor if changes in the behavior of all the resident. Resident #1 was seen by the primary physician, report was done see lates assessment (attachment of resident # 1) 7. The facility will ensure that all new admission of are non Alzheimer (see copy of Resident #1 when she was admitted to the group home dated 02/08/21 and copy of latest PCP assessments dated 04/5/22 8. The facility and the administrator will ensure that all admission are in compliance with the guidelines of the licensure and following the endorsement of the facility.	
0960	Alzheimer's Care Application for	0960	A. NAC-449-191 OR 449.1915	04/06/202

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SS= D	Endorsement - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer ' s disease. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on interview and record review, the facility failed to obtain an Alzheimer's endorsement before admitting residents with diagnosis of dementia and exhibiting wandering behavior for 2 of 2 residents with dementia (Resident #9 and #1). Findings include: The facility was not endorsed/licensed to admit residents diagnosed with Alzheimer's or other related dementia. Resident #9 Resident #9 was admitted to the facility on 12/08/11, with diagnoses including dementia with delusion and psychosis. Resident #1 Resident #1 was admitted to the facility on 02/08/21, with diagnoses including schizoaffective disorder and insomnia. Resident #1's history and physical dated 02/08/21, documented there was a concern for undiagnosed dementia after Resident #1 had walked away from their daughter's home. The resident was only alert and oriented to self. On 01/31/22 at 9:56 AM, the Caregiver explained on 01/19/22, Resident #1 had disappeared from the facility. There was a resident who always went out in front of the facility multiple times a day and upon entering the facility, was to lock the door. This particular day, the resident did not lock the door and Resident #1 left the facility while the Caregiver was in the back of the house doing laundry. Resident #1 was not		1.Please find medical report of resident #1 2.Please find the medical report of resident #9 3.Alarm is now installed in the front door 4. Resident #1 and resident #9 do not have a diagnosis of Alzheimer see (attachment . Physician placement determination, upon admission and the copy of the new placement assessments signed by the primary doctor 5. Resident #1 verbally told us that she only walk out of the facility to visit her family, that she promise that she will not do this problem again. 6. This facility is a non-Alzheimer facility (see medical report of resident #1 and resident #9) 7. Resident #1 can still relate, talk to her payee and told the payee all the personal hygiene needs and resident #9 still manage her own finances with occasional checkup of her son. 8. Resident #1 left the facility to visit her daughter and her grand kids. 9. The facility talk to resident #1 not to go out with out permission and that if she wants to see her daughter and grand kids we will drive her to their place . B. plan of care 1. alarm is installed in the front door (see picture) 2. Resident are monitor all the time to avoid elopement 3. The administrator and the caregiver will talk to the resident and ask if they want to go out of the facility. 3. The facility, caregiver and the administrator will ensure that this problem will not happen again.	2

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	discovered missing for approximately two hours. The resident had left the facility around 1:30 PM. Once the Caregiver realized Resident #1 was not present in the facility, the Caregiver walked up and down the street, however did not locate Resident #1. The Caregiver called the Owner who then called 9-1-1. The responding police officers located the resident near a casino, approximately three blocks away from the facility, and returned the resident to the facility at 7:00 PM. The Caregiver verbalized no alarms were on any of the doors leading outside and the door was left unlocked, resulting in Resident #1 eloping from the facility. The Caregiver explained Resident #1 had memory problems and had no idea where they were going. The Caregiver verbalized they were the only caregiver on duty in the facility and was usually left to supervise the residents on shift by themselves. The Nevada Division of Health Care Finance and Policy (DHCFP) Serious Occurrence Report dated 01/19/22, documented Resident #1 had left the facility at approximately 1:00 PM on 01/19/22. The Caregiver attempted to look for the resident upon discovering the resident missing. The police department was called and officers were able to locate the resident near a casino and bring the resident back to the facility. Severity: 2 Scope: 1			