STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11051	A. BUILDING _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WRIGHT GROUP HOME OF LOVELOCK	685 AMHERST AVE, LOVELOCK, NEVADA ,89419

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual, State Licensure survey conducted at your facility on 02/22/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or mental illness and/or Alzheimer's disease, Category II residents. The census at the time of survey was six. Six resident files, one closed record and five employee files were reviewed. The facility received a grade of C. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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 deficiencies were identified:	0000		
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse	0074	Based upon your findings Employees #2 and #3 were hired on January 19, 2024 and February 10, 2024, respectfully. However, the new owner thought that Employee #4 and #5 were there while owner was doing the orientation of both Employees #2 and #3 before training was done. We are aware that training will happen before hiring and will never happen again. That the Administrator will monitor the training and it will be done based upon State guidelines.	04/05/2024

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	of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and			

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	violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 2 of 5 sampled employees had initial elder abuse prevention training prior to working with residents (Employee #2 and #3). Findings include: Employee #2 Employee #2 was hired by the facility as a			

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	Caregiver with a start date of 01/19/24. Employee #2's personnel file contained elder abuse training dated 01/23/24. Employee #3 Employee #3 was hired by the facility as a Caregiver with a start date of 02/10/24. Employee #3's personnel file contained initial elder abuse training dated 02/19/24. On 02/22/24 at 11:30 AM, the Owner verbalized elder abuse training was to be completed upon hire and prior to employee's working with residents. The Owner confirmed Resident #2 and Resident #3's elder abuse trainings were completed after the employee's began working with residents. Severity: 2 Scope: 2			
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 caregivers were fingerprinted within 10 days of hire and received a background check clearance to work. (Employee #5). Findings include: Employee #4 Employee #4 was hired at the facility as a Caregiver on 01/03/22. Employee #4's Proof of Electronic Fingerprint Submission dated 07/31/23, documented fingerprints were submitted on 07/31/23. Employee #4's Notification of Clearance dated 08/28/23, documented a background investigation had been completed for Employee #4. On 02/22/24 at 12:04 PM, the Owner verbalized Employee #4 was hired at the facility on 01/03/22, however the background check was not completed until July 2023, when the Employee physically began working at the facility. The Owner confirmed fingerprints and background checks should be completed upon hire. Severity: 2 Scope: 1	0104	Based upon your findings on NAC449.200 background checks and personal files (NRS 449.0302, Employee #4 on record was to submit for fingerprinting for the reason that we had regular caregivers working in the facility before inspectors came. Owner had to look for relievers to help us out. We will monitor and assure inspectors that this will not happen again.	04/05/2024
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are	0178	Since we took over this facility we have maintained an A grade. The new owner caregivers were oriented on this area on health and sanitation failed to maintain the facility both in and out of the building. Administrator will review their daily routine	04/05/2024

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	well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure a designated exit was not blocked and a leaking sink was repaired. Findings include: Blocked Exit On 02/22/24 at 9:50 AM, a folding chair was jammed under the doorknob of the back door, blocking the back door. The back door had a green exit sign over the door, designating the door as an exit. An Exit Plan posted on the wall next to the kitchen designated the back door as an exit. The Exit Plan documented two exits. On 02/22/24 at 9:55 AM, a Caregiver verbalized the folding chair was placed under the door to prevent wandering residents from exiting. The Caregiver explained the door led to a fenced back yard. The Caregiver removed the chair and attempted to open the door; however, the door would not open. A keypad was located on the wall next to the door. The Caregiver was unable to open the door with the keypad and explained they did not know the code to the exit. The Caregiver confirmed the door was a designated exit on the Exit Plan and would need to be assessable in case of emergency. On 02/22/24 at 12:15 PM, the Owner verbalized the door was a designated exit and the code for the back door was the same as the code for the front door. The Owner confirmed it was not appropriate to block the door with a chair. Leaking Sink On 02/22/24 at 10:27 AM, a large bowl filled with cloudy, dark gray, foul smelling water was located under a section of pipe under the kitchen sink. On 02/22/24 at 10:30 AM, a Caregiver verbalized the bowl was under the sink because the sink leaked water. The Caregiver confirmed the bowl of water was gray and foul smelling and admitted the bowl of water had not been dumped in more than a week. On 02/22/24 at 12:30 PM, the Owner verbalized the sink had been leaking and was not sure how long it had been leaking. Severity: 2 Scope: 3		and check from time to time. New caregiver forgot that we have an alarm in the facility. They are not supposed to put anything that will block the door. Caregivers were advised to read the orientation guide which includes the Exit Signs and fire drills. The leaking sink had been fixed on March 15, 2024. Also owner installed new dishwasher. See attachments. The owner lost sight of this as the previous caregivers did not notify the owner of the problem. Administrator will monitor the building maintenance.	

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0430 SS= D	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation and interview, the Administrator failed to ensure the smoking policy was posted in the facility. Findings include: On 02/22/24, during the initial tour of the facility, the smoking policy was not located as a posting. On 02/22/24 at 10: 39 AM, a Caregiver verbalized the facility had one resident that smoked. The Caregiver verbalized the smoking policy was in each resident's file. The Caregiver confirmed the smoking policy was not posted in the facility. Severity: 2 Scope: 1	0430	The owner was not aware that the "No Smoking" sign had to be placed on the wall of the facility but just in their files. However, a big sign has been placed on the wall and has complied with requirement. See attachment.	04/05/2024

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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 a first aid kit contained a cardiopulmonary resuscitation (CPR) mask. Findings include: On 02/22/24 at 10:50 AM, during the facility tour, the first aid kit did not contain a CPR mask. On 02/22/24 at 10:53 AM, a Caregiver verbalized the first aid kit did not contain a CPR mask. The Caregiver confirmed the facility did not have a CPR mask in the facility. Severity: 2 Scope: 1	0451	Based upon your findings our First Aid Kit needed a CPR Training Mask. We will assure you that our kit will be provided with a CPR Training Mask. Owner was not aware that a CPR Training Mask was not included in our Kit. Will monitor all needed requirements for the First Aid Kit.	04/05/2024
0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an annual general physical examination was completed timely for 2 of 6 sampled residents (Resident #2 and Resident #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 08/20/22, with diagnoses including dementia and failure to thrive. Resident #2's clinical record documented a general	0859	Resident #2 when admitted should have have had a history and physical from the hospital or facility which was provided when admitted but needs a physical examination annually done by physician after admission. The Administrator will see that this is done and will not happen again. Resident #3's record was completed on February 8, 2022 and an annual examination was completed on June 13, 2023, but was late. Since the physician does not come in to the facility on a regular schedule as he is booked months out we will look at other options. Administrator will monitor examination dates.	04/05/2024

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	physical examination completed on 09/30/22, however, lacked documented evidence a general physical exam was completed in 2023. On 02/22/24 at 11:06 AM, the Caregiver confirmed Resident #2's clinical records lacked evidence of a general physical examination for 2023. The Caregiver confirmed general physical examinations were to be done on or prior to admission and completed annually thereafter. Resident #3 Resident #3 was admitted to the facility on 02/10/22, with diagnoses including hypertension, type II diabetes mellitus and chronic obstructive pulmonary disease. Resident #3's clinical record documented an initial physical exam completed on 02/08/22, and an annual 06/13/23. The 2023 physical exam was completed 125 days late. On 02/22/24 at 11:16 AM, the Caregiver confirmed Resident #3's 2023 general physical examination was completed late. The Caregiver confirmed general physical examinations were to be done on or prior to admission and completed annually thereafter. Severity: 2 Scope: 2			

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation and interview, the Administrator failed to ensure medications were destroyed for one unsampled resident after the resident expired. (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 03/18/22, with diagnoses including atrial fibrillation, rheumatoid arthritis, and diabetes. Resident #7 expired on 11/19/23. On 02/22/24 at 11:55 AM, during the medication review for Resident #4, two bottles of medication for Resident #7 were in the basket with Resident #4's medications. The medications identified: -senna plus 8.6-50 milligram (mg), take one tablet by mouth once daily -promethazine 25 mg tablet, take one tablet as needed for nausea or vomiting On 02/22/24 at 11:57 AM, the Caregiver confirmed the two bottles of medication were found with Resident #4's medications and Resident #7 was no longer in the facility. The Caregiver confirmed medications needed to be disposed of immediately after a resident expired. Severity: 2 Scope: 1	0885	After the resident expired all medications have to be destroyed by the hospital nurse. Previous caregivers did not submit all the medications for destruction. New caregivers failed to check the medications that did not belong to the resident. Orientation and education regarding medication management will be gone over with caregivers. Administrator will monitor regularly.	04/05/2024

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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 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 record review, document review and interview, the Administrator failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 6 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 02/10/22, with diagnoses including hypertension, type II diabetes mellitus and chronic obstructive pulmonary disease. Resident #3's physician order, dated 06/12/23, documented loperamide 2 milligram (mg) tablet, take one tablet orally every six hours as needed for diarrhea. Resident #3's February MAR lacked the physician's order for loperamide 2 mg tablet. On 02/2224 at 12:15 PM, the Caregiver confirmed the medication was not documented on the MAR and verbalized there was no way to know definitively if the medication had been administered. Severity: 2 Scope: 1	0895	Resident #8's physician's order for Loperamid 2mg tablet, take one (1) tablet every six (6) hours PRN for diarrhea, should have been discontinued if it was not needed anymore. Will have to notify the doctor that the resident's medication is no longer needed and has to be discontinued. Should be documented on the MAR for a discontinued medication. Caregiver to undergo medication training. Administrator will follow up.	04/05/2024

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure over-the-counter medications were labeled with the resident's name and the physician's name for 1 of 6 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 08/16/22 with diagnoses including atrial fibrillation and hypertension. On 02/22/24 at 11:55 AM, Resident #4's medication basket contained a bottle of acetaminophen 500 milligram (mg) tablets. The medication container was not labeled with the resident's name and the provider's name. Resident #4's physician order dated 09/25/22, documented acetaminophen 500 mg tablets, take one tablet by mouth two times a day. On 02/22/24 at 11:56 AM, the Caregiver explained over-the-counter medication required the resident's name and the physician's name on the bottle. The Caregiver confirmed the medication container lacked the required information on it. Severity: 2 Scope: 1	0923	Resident #4's over the counter medication of acetaminaphen 500mg should be labeled with the resident's name and the physician's name respectively. See attachment. Medication training and orientation needed for new caregivers. Administrator will follow up.	04/05/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WRIGHT GROUP HOME OF LOVELOCK	685 AMHERST AVE, LOVELOCK, NEVADA ,89419

(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
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 6 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 02/10/22, with diagnoses including hypertension, type II diabetes mellitus and chronic obstructive pulmonary disease. Resident #3's clinical record documented an ADL assessment had been completed on 02/09/23, however, lacked documented evidence an ADL assessment was completed for 2024. On 02/22/24 at 11:16 AM, the Caregiver verbalized ADL assessments were required to be completed upon admission and annually thereafter. The Caregiver confirmed Resident #3 did not have an ADL assessment completed for 2024. Severity: 2 Scope: 1	0938	Resident #3's ADL assessment completed on February 9, 2023 and an annual assessment was also done on February 8, 2024 per record on file. See attachment. Administrator will continue to monitor and follow up on this regularly.	04/05/2024