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
	1796	A. BUILDING _____ B. WING _____	01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY GROUP CARE 2	1140 MANHATTAN STREET, RENO, NEVADA ,89512

(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 State Licensure annual grading survey conducted at your facility on 01/09/23 and completed on 01/23/23. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category II residents. The census at the time of the survey was eight. Eight resident files were reviewed, and four employee files were reviewed. Your facility has received a A grade for this inspection. 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:	0000		
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 maintain the contents of a first aid kit required by Nevada Administrative Code 449.231(2)(a-f). Findings include: On 01/09/22, a review of the facility's first aid kit lacked a shield or mask for use in administering cardiopulmonary resuscitation (CPR). On 01/09/22 at 9:39 AM, the owner confirmed the first aid kit lacked a CPR shield/mask. Severity: 2 Scope: 1	0451	#2 TAG0451 NAC 449.231 (NRS 449.0302) The owner purchased the missing CPR Mask to be used at the said facility. The owner will also do a monthly inventory of facility first aid kits to see to it that we have everything we need in case of emergency and will be in compliance. Please see attachment.	02/04/2023

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: WARLITO PIZARRO Title: RFA Date: 02/04/2023

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the Administrator failed to ensure a medication review was completed at least once every six months for 2 of 8 sampled residents residing in the facility for longer than six months (Resident #1 and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/26/20, with diagnoses including diabetes, asthma, and hypertension. Resident #1's file contained a medication review dated 02/07/22, and 11/01/22, however, the resident's file lacked documented evidence of a six-month medication review completed by 08/07/22. On 01/09/23 at 10:03 AM, the Owner verbalized the pharmacy review should have been completed by 08/07/22, and the pharmacy review was not completed for Resident #1 until November 2022. Resident #5 Resident #5 was admitted to the facility on 01/29/21, with diagnoses including dementia without behavioral disturbances, dysphagia, and insomnia. Resident #5's file contained a medication review dated	0870	#3 TAG0870 NAC 449.2742 The owner was able to contact residents 1 and 5 Primary Care Physicians and obtain a Medication Review for both residents. The owner also spoke with the administrator and agree to do a monthly review of resident file. Please see attachment.	02/04/2023

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	01/18/22, and 11/02/22, however, the resident's file lacked documented evidence of a six-month medication review completed by 06/18/22. On 01/09/23 at 11:43 AM, the Owner verbalized the pharmacy review should have been completed by 07/18/22, and the pharmacy review was not completed for Resident #5 until November 2022. Severity: 2 Scope: 1			
1540 SS= D	Cultural Competency Training Inspector Comments: Based on personnel file review and interview, the facility failed to ensure all employees received cultural competency training within 30 days of their date of hire for 1 of 4 sampled employees. (Employee #4). Findings include: Employee #4 Employee #4 was hired as a Caregiver with a start date of 11/20/22. The personnel record for Employee #4 lacked documented evidence the employee had completed a cultural competency course. On 01/09/23 at 12:18 PM, the Owner confirmed Employee #4 had not taken an approved cultural competency training course. Severity: 2 Scope: 1	1540	#4 TAG1540 Cultural Competency The owner ask the caregivers to do thier Cultural Competency Training today and was able to complete them. Moving forward, the administrator will do a monthly review of employee files to make that they are in compliance and that this deficiency will not happen again. Please see attachment.	02/04/2023
1700 SS= F	Annual Assessment of History of Each Resident Inspector Comments: Based on record review and interview, the facility failed to obtain a Standard Physician Assessment and Placement Determination for 7 of 8 residents (Resident #1, #2, #3,#4, #5, #6 and #7). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/26/20, with a diagnoses including diabetes, asthma, and hypertension Resident #1's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #2 Resident #2 was admitted to the facility on 12/21/22, with diagnoses including muscle weakness, idiopathic aseptic necrosis of the pelvis and malignant neoplasm of unspecified ovary. Resident #2's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #3 Resident #3 was admitted to the facility on 07/09/22, with diagnoses including mental health and	1700	#5 TAG 1700 Annual Assesment of History of Each Resident - Owner and Administrator was able to obtain all Annual Assesment for all Resident of our facility. The owner and the administrator agreed that they will do a monthly review of all resident file to prevent this from happening again. Please see attachments	02/04/2023

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	hypertension. Resident #3's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #4 Resident #4 was admitted to the facility on 03/31/21, with diagnoses including deep vein thrombosis, and cardiomyopathy. Resident #4's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #5 Resident #5 was admitted to the facility on 01/29/21, with diagnoses including dementia without behavioral disturbances, dysphagia and insomnia. Resident #5's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #6 Resident #6 was admitted to the facility on 12/22/22, with diagnoses including coronary artery disease, dyslipidemia and hypertension. Resident #6's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #7 Resident #7 was admitted to the facility on 11/29/22, with diagnoses including altered mental status, urinary incontinence, and microcytic anemia. Resident #7's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 01/09/23 at 10:14 AM, the Owner confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #1, #2, #3,#4, #5, #6 and #7 and was responsible to ensure all admission documents were accurately and entirely completed. Severity: 2 Scope: 3			