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
	8989	A. BUILDING _____ B. WING _____	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOFIA'S HOME	2612 WABASH CIRCLE, 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 at your facility on 02/24/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness and/or persons with intellectual disabilities, Category II residents. The census at the time of survey was five. Five resident files were reviewed 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 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		

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: CATALINA M ALVENDIA	Title: Owner	Date: 03/08/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8989	A. BUILDING _____ B. WING _____	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOFIA'S HOME	2612 WABASH CIRCLE, 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
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review and interview, the Administrator failed to 1) retain the work schedule in the facility for 1 of the past 6 months, 2) ensure the work schedule was complete, and 3) indicate on the work schedule the type of employee working each shift and shift times. Findings include: A review of the facility's written work schedules from August 2019 through February 2020 did not include the schedule for December 2019. The work schedules were missing the names of Caregivers for the following dates: 09/06/19, 09/07/19, 09/08/19, 09/09/19, 09/10/19, 09/11/19, 09/12/19, 90/18/19, 09/19/19, 09/20/19, 09/21/19, 09/21/19, 09/22/19; 10/01/19 through 10/31/19; 11/01/19 through 11/30/19; 01/03/20, 01/06/20, 01/25/20, 01/26/20; and 02/02/20, 02/09/20, 02/15/20, 02/16/20, 2/22/20, 02/23/20, 02/29/20. The work schedules did not reflect the number and type of employee scheduled to work each day. No indication was made on the schedules for shift times or live-in/stay-in status of the employees. On 02/24/20 at 10:55 AM, the Owner verbalized the schedule for December was missing. The Owner confirmed two staff members worked each day, even on the days in February 2020 for which only one name was listed on the work schedule. The Owner explained the shifts were 24-hours per day, as the Owner and Caregiver #1 lived at the facility and Caregiver #2 was a fill-in employee for them. When Caregiver #2 came to work, this employee worked a 24-hour shift. The Owner confirmed no indication of type of employee or shift time appeared on the written work schedules. Severity: 1 Scope: 3	0088	1. We will make sure that we will have a complete schedule indicating the type of employee and shift times and it will be kept for at least 6 months. 2. A schedule binder was made and the schedule will be put in the binder at the end of each month to ensure that it is properly kept. 3. The schedule will be checked for completeness and the schedule binder too to check if the old schedule was placed in it. This will be done monthly. 4. The owner and the administrator. 5. It was completed after the survey on 24Feb20. Please see attached.	02/24/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8989	A. BUILDING _____ B. WING _____	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOFIA'S HOME	2612 WABASH CIRCLE, 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
0910 SS= A	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to document the reasons for administration of an as needed medication and its effect for 1 of 5 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 01/21/20 with diagnoses including dementia, hypertension, and stroke. Resident #4's Medical Administration Record (MAR), dated February 2020, documented triamcinolone 0.1% cream, apply to affected rash on arms and back twice a day as needed. The resident's MAR revealed the medication was administered at 8:00 AM and 8:00 PM on 02/08/20, 02/09/20, 02/10/20, 02/11/20, 02/12/20, 02/13/20, 02/14/20, 02/15/20, 02/16/20, 02/17/20, 02/18/20, 02/19/20, 02/20/20, 02/21/20, 02/22/20, and 02/23/20, and at 8:00 AM on 02/24/20. However, the Owner failed to document the reason for the administration and the results of the medication administration. On 02/23/20 at AM, the Owner verbalized not having written in Resident #3's MAR why the medication had been administered and its effect. The Owner expressed the resident's rash was in the process of healing. Severity: 1 Scope: 1	0910	1. Retraining was done on how to complete the documentation for a PRN medication when given. 2. Caregivers will make sure that proper documentation will be made when a PRN medication is given and will double check the documentation for completeness everyday. 3. Administrator will check the MAR monthly including the documentation for PRN medications. 4. Administrator and caregivers. 5. It was corrected on 24Feb20. Please see attached	02/24/2020
0938 SS= F	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	0938	1. ADL assessment was done with every Resident not just on the day of the admission but the next day because the Caregiver still had to assess the Resident's ability to do the Activities of Daily Living.	02/24/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8989	A. BUILDING _____ B. WING _____	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOFIA'S HOME	2612 WABASH CIRCLE, 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
	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 prepare an evaluation of a resident's ability to perform activities of daily living (ADL) upon admission for 3 of 5 residents (Resident #1, #2, #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/25/18 with diagnoses including dementia and acute kidney injury. Resident #1's medical file included an initial ADL assessment, dated 10/26/18, the day after the resident was admitted. Resident #2 Resident #2 was admitted to the facility on 09/23/19 with diagnoses including mild cognitive disturbance and bipolar disorder. Resident #2's medical record included an initial ADL assessment, dated 10/01/19, eight days after the resident was admitted. Resident #3 Resident #3 was admitted to the facility on 07/23/19 with diagnoses including dementia with behavioral disturbance, anemia, and stroke. Resident #3's medical record included an initial ADL assessment, dated 07/28/19, five days after the resident was admitted. On 02/24/20 at AM, the Owner verbalized sometimes waiting a few days after a new resident was admitted to complete the assessment of activities of daily living as a way to ensure the resident's prior placement's ADL evaluation was correct. The Owner		Some Residents were admitted later in the afternoon or at night that accurate ADL assessment will not be possible. We will do the ADL assessment on the day of admission of whatever will be observed with the Resident and fill up a new one whenever we need to make changes. 2. Caregiver double check the Resident's file and make sure that the ADL is done upon admission. 3. Administrator will check the Resident's ADL monthly to ensure that it's done in a timely manner. 4. Administrator and Caregiver. 5. On 24Feb20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8989	A. BUILDING _____ B. WING _____	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOFIA'S HOME	2612 WABASH CIRCLE, 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
	described situations in which the ADL assessments were not correct. The Owner verbalized the regulation indicated an initial ADL assessment was to be made upon admission. Severity: 2 Scope: 3			