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 _____	**01/18/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V N SENIOR CARE OF THE VINEYARDS	**1931 W VINEYARD DRIVE SOUTH, PAHRUMP, NEVADA ,89048**

(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 completed at your facility on January 18, 2019. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was nine. The sample size was one. There was one complaint investigated. Complaint #NV00055987 with one allegation was substantiated. Allegation #1 - The facility failed to provide protective supervision resulting in a resident eloping was substantiated. (See TAG Y 515) A deficiency unrelated to the complaint was identified during the investigation (See TAG Y 994 & TAG Y 991). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARIANITA GEE Title: ADMINISTRATOR Date: 03/13/2019

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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0515 SS= D	449.259(1)(a) - Supervision of Residents - NAC 449.259 Supervision and treatment of residents generally. 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary. Inspector Comments: Based on record review and interview the facility failed to ensure a resident was provided necessary protective supervision (Resident #1). Findings include: Resident #1 (R1) was admitted on 10/11/18, with a primary diagnosis of Alzheimer's disease. On 1/18/19, in the afternoon, an interview with Employee #1 (E1) reported administering R1 medication on 12/10/18 and then taking R1 to the bedroom to lay down. While E1 was assisting other residents a call was received from the Nye County Sheriffs office indicating R1 was found in the street. On 01/18/19, in the afternoon, review of incident report dated 12/10/18, indicated E1 had administered R1 medication at dinner time and afterwards took R1 to the bedroom to lay down. E1 then went to assist other residents when the Nye County Sheriffs office called at 6:10 PM on 12/10/18. The Sheriff's office reported they had found R1 walking in the street. On 1/18/19 Review of Nye County Sheriffs report dated 12/10/18, revealed R1 knocked on an individual's door and reported being pushed out of a vehicle. Upon arrival, the officer identified R1 and was advised R1 was listed as an Alzheimer patient. The officer contacted the facility and informed them R1 was with located and R1 would be returned to the facility. Severity: 2 Scope: 1 Complaint #NV00055987	0515	A) This facility is currently looking into additional methods to assist with residents safety. Currently we have instructed our Employees to due periodic checks on our residents and notify the Administrator of any malfunctions in the current system in place. Employees are also instructed to never disengage current alarm system under any circumstance. B) The owner will implement any worthwhile system that will benefit the safety of our Residents. We are determined to improve our service to our community of Residents. Any resident we feel is a flight risk, we will work with the physician to determine the cause to better protect the resident. C) The Owner and Administrator will monitor this outcome and substantial improvement. D) 2/21/2019	02/21/2019
0991 SS= F	449.2756(1)(b) - Alzheimer's Fac door alarm - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used	0991	A) At the time of the BHCQC visit, the left side door batteries died and was replaced by the owner. All doors were operable at the time of the elopement. The owner has been attempting to work with the PHYSICIAN to help Resident#1 with her restlessness and agitation, only after this incident were we able to get the help	02/21/2019

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	to exit the facility. Inspector Comments: Based on observation, interview, and record review the facility failed to ensure 1 of 3 exit door alarms activated when the door was opened to prevent an elopement for 1 sampled resident (Resident #1). Findings include: Resident #1 Resident #1 was admitted on 10/11/18, with a diagnoses Alzheimer's. Resident #1's Resident Incident Report Form dated 12/7/18, indicated the resident attempted to elope from the facility by jumping the fence. On 1/18/19 at 1:00 PM, Employee #1 indicated due to the attempted elopement on 12/7/18, the facility informed the resident not to elope from the facility again. The employee indicated the resident was confused at times. There were no other interventions placed to prevent the resident from eloping again other than informing the resident not to elope. On 1/18/19 at 1:00 PM, Employee #1 reported Resident #1 had eloped a second time from the facility on 12/10/18. The employee indicated the resident was placed into bed and was last seen in the facility at 5:25 PM. The employee indicated they received a phone call from the police at 6:10 PM informing them the resident was under their custody and found down the street from the facility. The employee was not aware the resident had eloped until the police called. Employee #1 further reported on the evening of the elopement on 12/10/18 the door alarm was not heard when the resident eloped due to the alarm being inoperable or not audible. On 01/18/19 at 1:00 PM, the facility side door alarm failed to sound when the door was opened. Employee #1 acknowledged the alarm did not activate when the door was opened and indicated caregivers sometimes disconnected the alarm because it startles the residents. On 01/18/19 at 1:00 PM, the employee acknowledged the alarm should always be on 24 hours a day and should not have been disconnected. Severity: 2 Scope:		needed. Now resident #1 is assisting and asking to assist, with small things of course. We believe Employee#1 did not hear the alarm and has always been instructed to never disconnect the alarm under any circumstance. Current employees are being replaced by 2/28/2019. All batteries will be replaced every 5 months to ensure no gaps in coverage. B) All future Employees will be instructed to perform random checks and never disconnect alarms. C) Owner and administrator will assume responsibility to maintain and ensure instructions are in compliance. D) 2/21/2019	

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0994 SS= F	449.2756(1)(e) - Alzheimer's facility - Dangerous items - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure a dangerous item was inaccessible to the residents. Findings include: On 01/18/19 at 1:10 PM, during a tour of the facility, a portable electrical stove was unsecured on the left side of the facility, within a gated area accessible to residents. On 01/18/19 in the afternoon, Employee #1 reported the facility had ambulatory residents who walk around the facility and had access to the area. Employee #1 acknowledged the portable electric stove should have been locked and kept inaccessible to the residents. Severity: 2 Scope: 3	0994	A) The owner used that stove to cook fish and the like on it and has been completely removed and it's utensils. B) The Owner has been advised by the Administrator, if using something as a portable stove to stow upon completion. C) The owner and Administrator will be responsible. D) 2/21/2019	02/21/2019