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 _____	**11/14/2023**

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 in your facility on 11/14/23 in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The census at the time of the survey was eight. The sample size was two. The facility received a grade of A. There was one complaint investigated. Verified: 1. Complaint #NV00069782 was verified. (See Tags Y88 and Y853) The investigation included: Observation of residents for evidence of pressure sores and changing after incontinence; residents exit seeking in the facility, resident bedding, room odors, locks and alarms on exit doors. Interviews were conducted with Residents, Hospice Representatives, a Visitor, and Caregivers. Clinical Record Review of two resident records, which included the residents of concern. Document Review included facility policy and procedures, Incident Report logs, and employee files. 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		
0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description	0853	Y0853 a) Incident Report was reported to Owner and Administrator on 11-2-23. (attachment #1) incident report include the following 1) DATE and time of accident or injury that was discovered 2) description the manner in which accident or injury was discovered 3) description of the manner in which a member of the staff responded to the accident or injury and file to incident report binder and available for review at by owner, administrator and surveyor. b) The administrator had a meeting with all caregivers instructed to	12/04/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: REBECCA N. WOLFKILL | Title: Administrator | Date: 12/12/2023

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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	of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report was filed after an elopement occurred for 1 of 10 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 07/03/23 with a diagnosis of dementia. On 11/14/23 in the afternoon, a resident was observed exit seeking and attempted to leave the facility with redirection from the caregiver. On 11/14/23 in the afternoon, a representative from a local hospice agency verbalized witnessing an elopement by R2 on a visit earlier in the month. The representative went running out the door after the resident. A neighbor told the representative R2 was by the Stop sign at the end of the street. As the representative got closer to the Stop sign, a medical transport van drove past, with Employee #1 (E1) (the Caregiver) and R2 in the van. On 11/14/23 in the afternoon, E1 and Employee #2 (E2) reported R2 had a history of trying to leave the facility unassisted in search of R2's parents. E1 and E2 shared when several visitors were at the facility all requiring Caregiver interaction it was hard to keep track of all the residents. They recounted one such incident recently in which R2 had gotten out of the facility and gone down the street before E1 was able to follow R2 and bring R2 back to the safety. The facility's incident report binder lacked documented evidence R2 had eloped from the facility. On 11/14/23 in the afternoon, E1 and E2 acknowledged an incident report should have been completed and documented in the Incident Report binder for the recent elopement, as		check and count all residents on an on-going basis to ensure none of the residents walk out of the facility without permission. c) Caregivers instructed to check all exit doors and make sure all exit doors are locked and alarm are ON at all times. d)The owner and administrator will monitor for compliance. e) 12-4-23	

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	well as for any future elopements. Severity: 2 Scope: 1 Complaint #NV00069782			
0992 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768. Inspector Comments: Based on observation and interview, the facility failed to ensure at least one member of the staff was awake at the facility at night. Findings include: On 11/14/23 in the afternoon, a resident was observed exit seeking and attempted to leave the facility with redirection from the caregiver. On 11/14/23 in the afternoon, Employee #1 (E1) and Employee #2 (E2) reported R2 had a history of trying to leave the facility unassisted in search of R2's parents. On 11/14/23 in the morning, a hospice representative was visiting Resident #1 (R1), whom the hospice representative stated was bedbound. The hospice representative expressed concerns about the staffing. The representative felt R1 sat in a wet diaper for too long and did not get changed enough. On 11/14/23 in the morning, R1 indicated they had to yell to get the employees' attention at night, after the employees went to bed. R1 reported being left wet in bed at night after the employees went to bed. On 11/14/23 in the afternoon, E1 and E2 explained they have been the two regular caregivers since they were hired in April of 2019 and they lived at the facility.	0992	Y0992 a) There are 3 CNA's that work for Resident #1 . CNA #1 work 2x a week Saturday and Tuesday. CNA #2 work 2x a week Thursday and Sunday. CNA #3 work 3x a week Monday, Wednesday and Friday. Plus 2 regular caregivers. b) The printed staffing for the month of December on display on the wall (attachment #3) the November staffing (attachment #4) was kept on the employee schedule binder. There are 2 regular caregivers during the day on schedule and one caregiver at night and awake. The owner called every night to ensure the caregiver on site is awake. c) The Administrator will be notified for any changes. The owner and administrator will monitor for compliance. d) 12-2-23	12/04/2023

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	There were two other staff that helped out occasionally, however E1 and E2 had very few days off and worked 24 hours shifts most days. Recently, E1 and E2's only scheduled days off were on October 2 and 3, 2023 (E1 only); and September 17 and 18, October 17, November 9 and 10 (E2 only). E1 and E2 worked together in the daytime. The facility did not have staff scheduled to work at night. E1 admitted to going to sleep at night after getting the residents ready for bed, and waking up periodically to check on and change the residents. Severity: 2 Scope: 3			
0088 SS= A	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 observation and interview, the facility failed to ensure a written staff schedule which included the number and type of staff members assigned to each shift was available. Findings include: On 11/14/23 in the morning, a written staff schedule was unavailable for the surveyor. On 11/14/23 in the morning, Employee #1 (E1) and Employee #2 (E2) explained there was no written staff schedule for the facility. E1 and E2 indicated they lived at the facility and were the only regular caregivers, with occasional help from the Owner and the Owner's spouse. On 11/14/23 in the morning, the Caregivers acknowledged a written staff schedule should be maintained within the facility. Severity: 1 Scope: 1 Complaint #NV00069782	0088	Y0088 a) The staffing schedule is posted on the wall the month of December 2023. The previous month was filed and retained for 6 months on the schedule binder. b) The schedule consist of 2 caregivers that work during the day and one caregiver work night shift. The husband and owner are available to cover the night shift in the event nightshift will not make it to work. The amended schedule will retain on file and available to view by surveyor when necessary. c) The owner and administrator will monitor for compliance. d) 12-2-23	12/04/2023