ccepted POC PC 9/17/08

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN4520ADA | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED 08/20/2008 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACTION II | 3680 EL RANCHO DRIVE SPARKS, NV 89433 |

| (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) COMPLETE DATE |
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| D 000 | Initial Comment<br><br>The findings and conclusions of any investigation by the Health Division 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.<br><br>This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted at your facility on 7/28/08 and completed on 8/20/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.<br><br>Complaint #NV00018723 was substantiated. See Tag D0075. | D 000 | RECEIVED SEP 15 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA | |
| D 075 SS=D | NAC 449.114(1) Employees<br><br>1. A facility must have on duty, all hours of each day, members of the staff sufficient in number and qualifications to carry out policies, responsibilities and program continuity.<br><br>This Regulation is not met as evidenced by:<br>Based on interviews and record review from 7/28/08 to 8/20/08, the facility did not provide adequate staff supervision for 1 of 8 residents.<br><br>Findings include:<br><br>Record review revealed Resident #1 was admitted on 5/15/08. Three staff members present during the resident's admission assessment denied that the resident's social worker informed them of the resident's past history of drinking mouthwash to become intoxicated. Facility notes from 6/9/08 to 6/18/08 | D 075 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dorothy B North   TITLE CEO   (X6) DATE

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| D 075 | Continued From page 1<br>indicated the resident was doing well during his stay in the facility and experienced no negative behaviors.<br><br>Multiple interviews with staff revealed that a new rehab tech (Employee #1) was tasked with supplying her facility and the facility under investigation with supplies. Employee #1 stated that on 6/10/08, she asked the administrative assistant for two bottles of hand sanitizers to be stocked in each facility. The employee reported she received two bottles and placed one bottle in a locked cupboard in her facility and handed the second bottle to the rehab tech (Employee #2), who was assigned to the facility under investigation. The employee stated she did not find out until later that the hand sanitizer bottles contained alcohol and that they were not suppose to stock the facilities with alcohol based hand sanitizer. The manager reported that normally the facility buys non-alcohol hand sanitizer in bulk, but they received some sanitizer containing alcohol from the local food bank and that sanitizer was accidentally put in each facility. The manager stated the facility did not have a written policy on the use of non-alcohol based hand sanitizer but reported, "it is just what we do." Employee #2 confirmed that he received a bottle of hand sanitizer from Employee #1. This employee stated that since Employee #1 brought over the hand sanitizer, he thought it was okay to use and he gave it to the cook, Employee #3. Employee #2 reported that he remembered seeing the hand sanitizer sitting by the kitchen sink, but could not recall if he saw the bottle the morning of 6/19/08. Employee #3, the cook, stated a rehab tech put a bottle of hand sanitizer on the kitchen sink the morning of 6/19/08 and asked him if he could use it. The cook stated the facility did not normally use sanitizer, but he told | D 075<br><br>OK pl | **D075**<br>**a)** Vitality Center/ACTIONS has corrected the deficiency to ensure that staff are on duty, all hours of each day, members of staff sufficient in number and qualifications to carry out policies, responsibilities and program continuity by implementing the following corrections: 1) Eliminating all alcohol-based products from the facility; 2) Hiring additional staff<br><br>**b)** Vitality Center/ACTIONS have taken the following actions to ensure the deficiency will not occur again: 1) Increased staff awareness of products containing alcohol; 2) Increased staff coverage<br><br>Vitality Center/ACTIONS will monitor the correction by ongoing staff training on products containing alcohol.<br><br>The staff member assigned to monitor to correction is the Regional Program Manager.<br><br>**c)** This was completed by 5-30-08. | |

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| D 075 | Continued From page 2<br>the rehab tech that he would use the sanitizer because he assumed it was cleared for use.<br><br>Additional interviews with staff revealed that Resident #1 was in good spirits the morning of 6/19/08, but woke up from a nap after lunch in a "bad mood." Employee #3, the cook reported the resident came downstairs with an attitude and got aggressive with the tech, himself and the other residents. Employee #2 stated he took the resident over to the manager's office because "he wasn't acting right - he was mad." Employee #2 reported the resident would not tell him why he was mad. The manager reported the resident was brought to her because he was agitated, but he refused to talk with her and spoke with Employee #4, a counselor, instead. Employee #4 reported she talked with the resident for about 15 minutes and he had calmed down before he left her office. Employee #4 stated he seemed mad at someone, but would not give her a name. After he left her office, Employee #4 reported the resident was escorted to the facility across the street. All of the employees interviewed were asked whether they thought the resident seemed under the influence during their interactions with him. They all denied the resident was exhibiting signs and symptoms of being under the influence of alcohol or drugs.<br><br>Further interviews with staff revealed that after Resident #1 returned to the facility across the street, he began acting strangely. Employee #2 stated he began fighting with the other residents and staff. Employee #2 reported the resident became mad and just "went off," so he called the main office for help. At the time of the call (4:30PM), the facility was holding a staff meeting and multiple staff persons ran across the street to help Employee #2. By the time they arrived at the | D 075 | | |

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| D 075 | Continued From page 3<br>facility the resident had choked and stabbed a tech with a pencil. The resident was physically restrained while the police were called. While restrained, Employee #4 stated she tried to comfort him by talking calmly to him. She stated he was sweating profusely, his eyes were red, bloodshot and dilated. She denied that he smelled of alcohol. Employee #2 denied the resident smelled of alcohol. The manager stated she thought he "smelled funny." Employee #4 stated she asked the resident if he was under the influence, but he would not answer her. The resident was removed from the facility by the police and taken to a juvenile detention center. The manager reported that an employee from the juvenile detention center called her later to report the resident blew 0.184 on the breathalyzer and told detention center staff he had drank hand sanitizer to get drunk. After the phone call, the manager reported she got rid of the remaining sanitizer in the office and checked all the facilities for sanitizer. The manager stated they did not find any sanitizer bottles in the facility where the resident lived. Employee #4 reported the resident's room was searched, but they did not find any sanitizer bottles either. The cook, Employee #3, reported the manager called him at home to ask him about the chemicals he kept in the kitchen. The cook stated he told the manager that he had kept a bottle of hand sanitizer in the kitchen.<br><br>During an interview with a juvenile probation officer, the officer confirmed that Resident #1's Breathalyzer test was 0.189 and he had been charged with battery and a minor in consumption. The officer also reported the resident was transferred to a local hospital for medical attention. Hospital records dated 6/19/08 | D 075 | | |

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| D 075 | Continued From page 4<br><br>indicated the resident reportedly told hospital staff that he drank a half a bottle of cleaning fluid. The resident ingested it at approximately 12:00PM and denied anything except for feeling "a bit buzzed." The resident denied any alcohol ingestion. The hospital records further indicated the resident's serum osmolarity was elevated at 354, likely secondary to alcohol. The resident's social worker reported that after he was returned to the juvenile detention center, he went in front of a judge for the battery and a minor in consumption charges. The social worker stated the resident admitted to the judge that he took the hand sanitizer from he kitchen and drank it to get drunk. When the judge asked him about the assault, the resident told the judge he did not remember what happened because he blacked out from the hand sanitizer.<br><br>After the 6/19/08 incident occurred, the manager reported they searched both facilities for the hand sanitizer and removed any bottles they found. The manager stated that hand sanitizer was not found in the facility under investigation. The manager stated the cook believed Resident #1 drank the one he had in the kitchen. When Employee #2 was interviewed about the resident taking the hand sanitizer in the kitchen while staff were in the facility, the employee reported that clients are allowed to move around the house, but they have to ask first. The employee also reported that sometimes the residents clean the kitchen for the cook. In addition, the employee reported it was possible the resident took the sanitizer and consumed it in the bathroom because staff are not allowed in the bathroom with residents. When Employee #3, the cook, was interviewed about the resident taking the hand sanitizer from the kitchen while staff were in the facility, the cook reported that he was in the | D 075 | | |

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| D 075 | Continued From page 5<br><br>kitchen most of the day on 6/19/08 and did not notice if the resident stole it. The cook stated that he could have been elsewhere in the facility when the hand sanitizer was taken, like the bathroom. The cook further stated that residents are supposed to be supervised, but they are allowed to get a drink from the kitchen alone. The cook also stated that when he reported to work the next morning (6/20/08), the hand sanitizer that was there the day before, was gone. Employee #2 and #3 all reported that facility only used hand soap now and no other chemicals were allowed in the open. The manager indicated in an incident report form that she made it very clear that no products were to be in any of the buildings that contain alcohol, including the main office.<br><br>While under staff supervision, Resident #1 was able to steal and consume a prohibited product containing alcohol that was left out in the open. As a result, the resident became intoxicated and assaulted staff members.<br><br>Severity: 3 Scope: 1 | D 075 | | |

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