Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	NVN5141HIC		C 01/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINITY HOMECARE	3944 KENTWOOD CT RENO, NV 89503

(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
H 000	Initial Comment This Statement of Deficiencies was generated as a result of a Complaint Investigation initiated in your facility on 12/30/08 and completed on 1/5/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. 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. The census at the time of the survey was one. Complaint NV00020420 was substantiated. See Tags H014, H017 and H019.	H 000		
H 014	Director Duties-Dignity, Respect; Not Abused NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (a) Are treated with dignity and respect and are not abused, neglected or exploited. This Regulation is not met as evidenced by: Based on record review, observation and interviews from 12/30/08 to 1/5/09, the director	H 014		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 014	Continued From page 1 failed to ensure that 1 of 2 residents were not abused (Resident #2). Findings include: The investigation was initiated at the facility on 12/30/08 and it was determined Resident #2 was no longer living in the home. The director, Employee #1, and the caregiver, Employee #2 were interviewed. They stated they were the only ones who worked at the facility and they took turns caring for the residents while the other was at work. Both employees stated Resident #2 had a lot of care needs, was very demanding and difficult to please. Resident #2 was interviewed at her new residence on 12/30/08 and she reported she felt Employee #2 was rude and demeaning in her interactions on an almost daily basis. She related that when she asked for more butter during a meal, the employee told her she was "too fat." The resident stated the employee also made comments that she was "too much trouble and too much work" and that she, Resident #2, was stinking up the house. The resident reported that on several occasions, Employee #2 threatened to not mail her letters. Resident #2 stated on one occasion, after she had been incontinent, Employee #2 yelled at her saying she would have to move out because she was too much work. Resident #2 reported when Employee #2 was not available, she would ask for help from Employee #1, but he told her she would have to wait for Employee #2 to help her. A friend who visited Resident #2 while she lived at the facility was interviewed on 12/30/08. The friend stated on one of her visits she found neither Employee #1 or #2 were in the home and	H 014		

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H 014	Continued From page 2 the residents had been left in the care of a female who did not speak English very well. The visitor found Resident #2 crying because she had been incontinent and Employee #2 had stripped the bed before leaving the facility. The resident told her the employee left the bed unmade so she, the resident, could not lay down in her room. A family member of Resident #2 was also contacted and interviewed on 12/30/08. In the interview, the family member reported he had not observed the facility staff being rude or abusive to Resident #2 but the resident had told him about how the staff was treating her. The family member stated he was paying the facility $100.00 a month above the agreed monthly rate to have the employees treat Resident #2 better.	H 014		
H 017	Director Duties-Protective Supervision NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (b) Receive: (3) Protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being. This Regulation is not met as evidenced by: Based on record review, observation and interviews from 12/30/08 to 1/05/09, the facility failed to provide adequate supervision to prevent the elopement on 12/6/08 of 1 of 2 residents (Resident #1). Findings include: During an interview on 12/30/08, a family member of Resident #2 stated he was contacted	H 017		

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H 017	Continued From page 3 by the local police department on 12/6/08 at about 6:30 AM regarding a confused woman (Resident #1) whom they had found at a shopping center near the facility. The police found his phone number in Resident #1's pocket and wanted to know the location of her residence so they could return her. On 12/30/08, an incident report was found in the file of Resident #1 documenting the incident on 12/6/08. The report indicated the resident had been found by the local police department at a local shopping center. The report showed the facility investigation determined Resident #1 exited the facility through a door that led from the kitchen to the garage and then got out through the garage. In the report it was noted that "extra precautions taken to make sure this does not happen again." Interview with the director, Employee #1, on 12/30/08 revealed he had reversed the dead-bolt lock on the door from the kitchen to the garage so it could not be opened from the inside without a key. He stated both he and Employee #2 carried keys to the door at all times. The director reported that all other exit doors had magnetic alarms that were turned on the night Resident #1 had eloped. It was noted the locks on the other exit doors did not require a key to be unlocked.	H 017		
H 019	Director Duties-Qualified Caregiver NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.	H 019		

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H 019	Continued From page 4 This Regulation is not met as evidenced by: Based on record review, observation and interviews on 12/30/08 through 1/5/09, the director did not ensure that 2 of 2 residents were supervised by a caregiver at all times (Resident #1 and #2). Findings include: Resident #2 was interviewed at her new residence on 12/30/08. During the interview, the resident stated that Employee #2 had a friend of hers stay at the facility with the residents while the employee went out shopping. On 12/30/08, a friend who visited Resident #2 at the facility was interviewed. The friend reported she visited the resident on a day the residents were left with a friend of Employee #2. She reported she arrived at the facility at about 2:00 PM on 11/13/08 and a small Asian woman who could speak minimal English would not let her inside until Resident #2 came to the door. The visitor stated she did not feel she could leave the residents without a caregiver who could speak English so she stayed with Resident #2 as long as she could. The visitor reported at 5:00 PM she called the resident's son to notify him of the situation and she stayed until he arrived at 5:15 PM. The son of Resident #2 was interviewed on 12/30/08 and said he made notes of the call he received from the friend of his mother's on 11/13/08. He reported the friend called at 5:00 PM and he arrived at 5:15 PM to find neither Employee #1 or #2 were in the facility. He stated he saw a female who said she was a friend of	H 019		

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H 019	Continued From page 5 Employee #2, the two residents and his mother's friend. The son reported he stayed at the facility with Resident #2 until Employee #2 returned to the facility at about 5:30 PM. Employees #1 and #2 were interviewed on 12/30/08 and both denied ever having anyone but one of themselves care for and supervise the residents in the facility. Employee #2 provided a phone number for a friend with a name similar to the one used by the female on 11/13/08. The friend of Employee #2 denied ever being in the facility.	H 019		