STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295015		C 02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE REGIONAL MED CTR SNF	825 ERIE MAIN/ PO BOX 391 TONOPAH, NV 89049

(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
F 000	INITIAL COMMENTS	F 000		
	This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on 2/12/09. Complaint #NV00020944 was substantiated. See F 323. The findings and conclusions of any investigation by the Health Division 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.			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 4 of 4 residents were unable to exit the building without supervision. Findings include: Four skilled nursing facility (SNF) residents had recently been readmitted to the facility after a plumbing leak had flooded the long term care unit. Two rooms with two beds each were located in the acute care section of the facility which had been designated as long term care for several	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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F 323	Continued From page 1 years. These rooms were outside the contiguous SNF unit and located in the acute care section of the facility. The four residents were placed in these rooms. An inspection of the double doors leading into a back hallway with an exit to the outside revealed no alarms or devices to alert staff if a resident opened the doors. The residents were originally located in rooms within ten feet of the double doors. On arrival at the facility, the residents had been moved to rooms located directly behind the nursing station about fifty feet from the double doors. Interview with staff indicated that one of the residents frequently got up during the night and was sometimes disoriented. The resident had to be redirected as she had tried to open the double doors. An interview with the Administrator revealed that it was possible for the residents to exit the building without being observed if the staff was busy with emergency room patients or other patients during the night shift.	F 323		