

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN4718AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTER FOR HOPE OF THE SIERRAS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 PASS DRIVE RENO, NV 89509</b>		
(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
Y 000	Initial Comments  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.  This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 2/17/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category I residents. The census at the time of the survey was five. Five resident files were reviewed and ten employee files were reviewed. One discharged resident file was reviewed.  The following deficiencies were identified:	Y 000		
Y 106 SS=E	449.200(2)(a) Personnel File - 1st aid & CPR  NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.  This Regulation is not met as evidenced by:	Y 106		

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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Y 106	Continued From page 1  Based on record review on 2/17/09, the facility failed to ensure that 2 of 10 caregivers were currently trained in first aid and cardiopulmonary resuscitation (CPR) (Employee #7 and #9).  This was a repeat deficiency from the 2/7/08 State Licensure survey.  Severity: 2 Scope: 2	Y 106		

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