Bureau of Health Care Quality and 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
	NVN3742AGC		C 12/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HILLS RES GRP CARE 3	8055 MOHAWK LANE RENO, NV 89506

(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 Surveyor: 25375 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 a complaint investigation conducted in your facility from 10/27/09 to 12/10/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for five Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category II residents. The census at the time of the survey was four. Four resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. Complaint #00023459 was substantiated. See Tag Y 050, Y 590 and Y 850 The following deficiencies were identified:	Y 000		
Y 050 SS=G	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC	Y 050		

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 050	Continued From page 1 449.156 to 449.2766, inclusive, and chapter 449 of NRS.	Y 050		
	This Regulation is not met as evidenced by: Surveyor: 25375 Based on record review and interviews from 10/27/09 through 12/10/09, the administrator of the facility failed to provide direction and oversite to facility staff to prevent the abuse of an elder resident (Resident #1) by a another resident (Resident #2) and failed to secure medical attention for injuries sustained in an assault. See Tags Y 590 and Y 850. Severity: 3 Scope: 1			
Y 590 SS=G	449.268(1)(a) Resident Rights	Y 590		
	NAC 449.268 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility.			
	This Regulation is not met as evidenced by: Surveyor: 25375			

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Y 590	Continued From page 2 Based on resident and staff interviews and record review from 10/27/09 through 12/10/09, the administrator failed to ensure that 1 of 5 residents (Resident #1) was not physically abused by another resident (Resident #2). Findings include: Resident #1 had lived in the facility for the past six years. The resident was an 83 year old man with a short, slight frame and the diagnosis of dementia. The admission assessment of needs indicated he required protective supervision. During an interview with the resident, he was able to recall multiple incidents in which Resident #2 assaulted him. Resident #2 was admitted to the facility on 3/31/09 with diagnoses of schizophrenia, a history of alcohol abuse, atherosclerosis and non-psychiatric brain syndrome. He was 54 years old, approximately five feet, eleven inches tall and weighed approximately 146 pounds at the time of his admission to the facility. The resident was originally assigned to a large double occupancy room, but was moved into a smaller room to be shared with Resident #1 on 9/30/09. Interview with a caregiver revealed a 10/9/09 incident between Resident #1 and Resident #2 in which Resident #2 assaulted Resident #1 twice. The caregiver reported she heard a disturbance coming from their bedroom and went to check on what happened. She reported Resident #1 was in the bathroom and she did not want to bother him. She could not remember where Resident #2 was at the time. After a second disturbance on 10/9/09, she found Resident #1 curled up on his bed. She reported Resident #1 told her that	Y 590		

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Y 590	Continued From page 3 Resident #2 hit him, but Resident #2 denied it. She admitted that she did not examine Resident #1 for injuries. She reported she did not consider separating the roommates at that time because her shift was over and her replacement had arrived. She reported that she told the next caregiver to "keep an eye on them." Interview with another caregiver revealed a third incident in which Resident #2 again assaulted Resident #1 by hitting him. This assault was reported to the caregiver by Resident #1 on 10/10/09 at 5:30 PM and the caregiver stated she told Resident #2 to leave Resident #1 alone. After the (fourth) incident on 10/10/09 at 7:15 PM, she found Resident #1 crying and doubled over holding his stomach. She reported Resident #1 told her Resident #2 had punched him in the left ear, the chest and abdomen. This caregiver reported that even though Resident #2 denied hitting Resident #1, she saw the bruises, red marks and the skin tear that verified this information. She reported she then called the facility manager to come over and help her. To protect Resident #1, staff transferred Resident #1 to a sister facility next door, but failed to call the police or the guardian to report the assault and injuries. Resident #1 reported during an interview that Resident #2 hit him many times, almost every day. Resident #2 denied living in the facility or having fought with Resident #1. After Resident #1 was first assaulted by Resident #2 on 10/9/09, the administrator failed to investigate the incident and failed to separate the two residents before additional abuse could occur.	Y 590		

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Y 590	Continued From page 4	Y 590		
	Severity: 3 Scope: 1			
Y 850 SS=G	449.274(1)(a) Medical Care of Resident	Y 850		
	NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available.			
	This Regulation is not met as evidenced by: Surveyor: 25375 Based on record review and interviews from 10/27/09 to 12/10/09, the facility failed to obtain medical care for 1 of 4 residents after a physical assault and failed to notify the resident's guardian about physical injuries sustained in the assault (Resident #1).			
	Findings include:			
	During interviews and a record review, it was discovered that Resident #2, a 54 year old male, had physically assaulted Resident #1, an 83 year old male. See Tag Y590. After the last assault on 10/10/09, a caregiver reported seeing bruises, red marks and a skin tear on Resident #1. The			

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Y 850	Continued From page 5 facility did not seek medical attention for Resident #1's injuries, but instead, transferred him to another sister facility next door. A staff person stated he saw the injuries as severe enough to move Resident #1 to another facility but he did not think they needed medical attention. The facility also failed to notify the Resident #1's guardian until three days after the 10/10/09 assault. After the guardian's office was sent an incident report dated 10/13/09, the guardian insisted Resident #1 be seen by a physician. Resident #1 received medical care on 10/13/09 for his injuries; three days after the assault. Severity: 3 Scope: 1	Y 850		
Y 944 SS=A	449.2749(2) Resident File - Discharge Documentation NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. This Regulation is not met as evidenced by: Surveyor: 25375 Based on record review and interview on 10/27/09, the facility did not provide proper	Y 944		

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Y 944	Continued From page 6 documentation regarding a resident who had been discharged (Resident #1). Severity: 1 Scope: 1	Y 944		