

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  Northern Nevada State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE  36 Battleborn Way Sparks, NV 89431	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43311</p> <p>Based on interview, clinical record review, and document review the facility failed to ensure a resident was not verbally abused by a Certified Nursing Assistant (CNA) when the CNA used profane language towards a resident for 1 of 5 sampled residents (Resident #2).</p> <p>Findings include:</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including post-traumatic stress disorder, chronic, major depressive disorder, single episode specified, and generalized anxiety disorder.</p> <p>An initial Facility Reported Incident (FRI) documented on the evening of 09/11/2024, Resident #2 reported the resident had been called a profanity by a CNA while in the resident's room. An investigation for verbal abuse was initiated. Resident #2 did not want the CNA to provide any further care to the resident.</p> <p>A final FRI documented the CNA was assigned to Resident #2's unit and had provided care to the resident that evening. The investigation was substantiated by the facility for employee verbal abuse.</p> <p>On 11/06/2024 at 11:02 AM, Resident #2 explained on the evening of 09/11/2024, a CNA had come into the resident's room to provide care. Resident #2 communicated being annoyed with the CNA and yelled for the CNA to leave. Resident #2 confirmed the CNA called the resident a profane word and felt angry a staff member would speak to a resident in that manner.</p> <p>On 11/06/2024 at 11:15 AM, the Regional Director of Quality and Clinical Services (RDQ) explained on 09/11/2024, Resident #2 reported a CNA had called the resident a profane word. The CNA admitted to the Director of Nursing (DON) to calling Resident #2 a profane word out of frustration with the resident. The CNA was escorted out of the building by the DON. The RDQ confirmed the CNA had verbally abused Resident #2.</p> <p>The CNA was suspended during the investigation, terminated, and reported to the State Board of Nursing.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled Abuse, Neglect, and Exploitation, revised 01/2023, documented abuse would include verbal abuse, sexual abuse, and mental abuse. Staff were trained on the appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. Staff was supervised to identify inappropriate behaviors, such as using derogatory language.</p> <p>The facility's policy titled Resident Rights, revised 01/2023, documented the resident had the right to be free from verbal, sexual, physical, or mental abuse, exploitation, corporal punishment, and involuntary seclusion. Residents would be treated with dignity and respect in full recognition of the resident's individuality.</p> <p>The facility's CNA job description, dated 01/2017, documented CNA common core roles included maintaining professionalism and composure when interacting with management, employees, residents, and families by being inclusive and respectful, working well with others, listening attentively and empathetically, and following up with resident expressed concerns.</p> <p>FRI #NV000072178</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43311</p> <p>Based on interview, clinical record review, and document review, the facility failed to 1) submit a Facility Reported Incident (FRI) initial report with accurate and complete information, and 2) submit a final report to the State Agency (SA) within the required five-day timeframe for 1 of 5 sampled residents (Resident #1).</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, vascular dementia, moderate with other behavioral disturbance, and anxiety disorder.</p> <p>On 09/06/2024, an initial FRI was submitted to the State agency for employee to resident verbal abuse towards Resident #1 during medication administration in the resident's room. The initial FRI was completed by the Administrator and documented the incident occurred on 08/27/2024.</p> <p>A final FRI was not received by the SA.</p> <p>On 11/06/2024 at 2:51 PM, the Regional Director of Quality and Clinical Services (RDQ) confirmed the previous facility Administrator had submitted the initial FRI and did not reflect an accurate date of occurrence. The RDQ confirmed the incident was reported to have occurred on 09/06/2024, and the facility did not complete or submit the final FRI to the SA. The RDQ verbalized the final FRI report was to be submitted within five days of the incident occurrence.</p> <p>The facility policy titled Abuse, Neglect, and Exploitation, last reviewed 11/2023, documented allegations of abuse, neglect, or exploitation would be thoroughly investigated. The investigation was initiated upon allegation receipt and the Administrator/designee would complete the investigation process. The results of all investigations were reported to the appropriate State Agency, as required by state law and/or within five (5) working days of the alleged violation.</p> <p>FRI #NV00072148</p>