DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**06/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMINA LAS VEGAS	**2710 WEST CHARLESTON BLVD, LAS VEGAS, NEVADA ,89102**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation and Facility Reported Incident completed at your facility on 06/24/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 35. The sample size was nine resident files and five employee files. The facility received a grade of B. There was one complaint and one Facility Reported Incident (FRI) investigated: Substantiated 1. Complaint #NV00071209 was substantiated (See Tags Y0503 and Y0850) 2. FRI #9883 was substantiated with no deficient practice. The investigation of the complaint and FRI included: Observations included a tour of the facility, no fall hazards in the facility, facility infection control practices, cleanliness of the facility, residents receiving care and assistance. Interviews were conducted with residents, one resident of concern, two Care Specialists, a Medical Technician, the Wellness Director, the Executive Director. Clinical Record Review of nine resident records, which included the resident of concern. Document review included facility policy and procedures, facility infection control training, facility communication to residents' responsible parties, and recent incident reports. The findings and conclusions of any investigation by the Division of Public and Behavioral Health 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 following regulatory deficiencies were identified:	0000		
0503 SS= F	Written Policies - Compliance with - NAC 449.258 Written policies for facility; policy on visiting hours; residents ' mail; compliance with policies. (NRS 449.0302) 4.	0503	1. All residents affected by the Gastrointestinal Illness have been reported to RedCap as of July 15, 2024. 2. RedCap account has been established	07/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NICOLE GRAHAM Title: Executive Director Date: 08/01/2024

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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	The employees of the facility shall comply with the policies developed pursuant to this section. Inspector Comments: Based on interview, record review, and document review, the facility failed to notify the proper State agency regarding Gastrointestinal Illness in the facility for 5 of 9 sampled residents. (Residents #1, #2, #3, #4 and #5) Findings include: The Facility Infection Control Gastrointestinal Illness/Norovirus Policy dated 04/17/23 documented upon suspected Gastrointestinal Illness outbreak, the following notification steps were taken: Notify the licensing agency and contact the appropriate county health department for guidance. Resident #1 (R1) R1 was admitted on 11/27/23, with diagnoses including age related tauopathy and dementia. A 05/14/24 Physician's Assessment documented R1 had norovirus and acute diarrhea. Resident #2 (R2) R2 was admitted on 03/13/24, with a diagnosis of dementia. A 05/14/24 Physician's Assessment documented R2 had norovirus and acute diarrhea. Resident #3 (R3) R3 was admitted on 12/18/23, with a diagnosis of dementia. A 05/14/24 Physician's Assessment documented R3 had norovirus and acute diarrhea. Resident #4 (R4) R4 was admitted on 01/09/24, with a diagnosis of dementia. A 05/14/24 Physician's Assessment documented R4 had been seen for three days of diarrhea with nausea and vomiting. A 05/21/24 Physician's Assessment documented R4 had tested positive for norovirus. Resident #5 (R5) R5 was admitted on 10/19/23, with a diagnosis of front temporal dementia. An Outside Agency Documentation Form dated 05/22/24 documented the resident had norovirus. A Facility Illness Tracking Form documented R1, R2, and R3 had signs and symptoms of diarrhea, nausea and vomiting onset on 05/12/24. R4 had signs and symptoms of diarrhea and nausea onset on 05/12/24. R5 had signs and symptoms of		and active for any future epidemiology required reporting as of July 2024. 3. ED/WD/Designee will review all illnesses and determine whether or not there is a reportable event and complete the reportable event as required and use the paper tracking form if and when needed. 4. The ED/WD/Designee will continue to monitor and report any findings to ensure we are reporting into the RedCap. 5. This was completed as of July 15, 2024. 6. GI Illness Tracker paper form	

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	diarrhea onset on 05/12/24. R1, R2, R3, and R4 were documented on the Facility Illness Tracking Form as having labs collected on 05/13/24. R1, R2, and R3 were documented as having received lab results on 05/16/24. R4 was documented as having received lab results on 05/18/24. A 05/19/24 email from the Executive Director to the State of Nevada Department of Health documented the facility was a new facility and needed to establish their Red Cap account to report outbreaks. On 05/20/24 a representative from the Nevada State Office of Epidemiology reported they reached out to the facility regarding norovirus at the facility. The Nevada State Office of Epidemiology documented the first illness onset date was on 05/12/24 with a total of 12 residents experiencing symptoms. On 06/24/24 in the afternoon, the Wellness Director verbalized residents began experiencing symptoms on 05/12/24. The facility believed it was a food related illness and the residents were seen by their Physician on 05/14/24. Residents who were experiencing symptoms were isolated pending results of their lab tests. The Wellness Director reported all residents were isolated as a precautionary measure on 05/17/24. On 06/24/24 in the afternoon, the Executive Director acknowledged the State of Nevada contacted the facility regarding the norovirus outbreak and verbalized the facility did not contact the Nevada State Office of Epidemiology because they did not have access to their Red Cap account. Severity: 2 Scope: 3 Complaint # NV00071209			
0850 SS= F	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 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 illness or at the time of the injury. The	0850	1. All residents affected by the norovirus outbreak, responsible parties have been notified. 2. ED/WD/Designee will review the policy/procedure for notifications of events and documentation with clinical team via in-servicing. 3. ED/WD/Designee will review all incidents to ensure a proper notifcations have been completed with documentation. 4. ED/WD/Designee will ensure	07/15/2024

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	facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on interview, document review and record review, the facility failed to ensure residents' responsible parties were notified of a change in condition for 5 of 9 sampled residents (Resident #1, #2, #3, #4 and #5). Findings include: Resident #1 (R1) R1 was admitted on 11/27/23, with diagnoses including age related tauopathy and dementia. A Facility Illness Tracking Form documented R1 had an onset of diarrhea, nausea and vomiting on 05/12/24. Resident #2 (R2) R2 was admitted on 03/13/24, with a diagnosis of dementia. A Facility Illness Tracking Form documented R2 had an onset of diarrhea, nausea and vomiting on 05/12/24. Resident #3 (R3) R3 was admitted on 12/18/23, with a diagnosis of dementia. A Facility Illness Tracking Form documented R3 had an onset of diarrhea, nausea and vomiting on 05/12/24. Resident #4 (R4) R4 was admitted on 01/09/24, with a diagnosis of dementia. A Facility Illness Tracking Form documented R4 had an onset of diarrhea, and nausea on 05/12/24. A 05/14/24 Physician's Assessment documented R4 had been seen for three days of diarrhea with nausea and vomiting. A 05/21/24 Physician's Assessment documented R4 had tested positive for norovirus. Resident #5 (R5) R5 was admitted on 10/19/23, with a diagnosis of front temporal dementia. A Facility Illness Tracking Form documented R5 had an onset of diarrhea on 05/12/24. An Outside Agency Documentation Form dated 05/22/24 documented the resident had norovirus. Resident files lacked documented evidence that the facility notified R1, R2, R3, R4 and R5's responsible party at the onset of their illness		communication is delivered to the appriopriate indivduals. 5. July 15, 2024. 6. In-service attached.	

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	on 05/12/24. On 06/27/24 in the morning, the Executive Director verbalized R1 and R4's responsible parties were notified after the facility received their tests results on 05/16/24 and not prior when the onset of diarrhea and nausea started. The Facility's Incident Policy dated 04/17/23 documented that incidents were reported immediately to the resident's family/responsible party and physician. Document the date and time the report was made to the family/responsible party and physician in the narrative charting section. Severity: 2 Scope: 3 Complaint# NV00071209			
1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control designees acquired the required initial 15 hour infection control training from the approved nationally recognized	1830	1. ED/WD are scheduled to complete the 15hours of required infection control training provided by the CDC by August 30, 2024. 2. ED/WD will ensure that their training is completed timely and certificates of completion will be maintained in their employee file. 3. Currently one wellness designee is already certified. Will continue to upload and monitor and maintain all records of ED/WD/designee in their employee file. 4. ED/WD/Designee 5. 7/31/2024	07/31/2024

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	organizations. (Employee #1 and #2) Findings include: Employee #1 (E1) E1 was hired on 08/08/22 as the Executive Director. E1's record lacked documented evidence of the initial 15 hours of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #2 (E2) E2 was hired on 02/01/24 as the Wellness Director. E2's record lacked documented evidence of the initial 15 hours of training concerning the control and prevention of infections from the approved nationally recognized organizations. On 06/24/24 in the afternoon, the Executive Director (E1) confirmed they were the primary and the Wellness Director (E2) was the secondary infection control designee and the required infection control and prevention training from a nationally recognized organization had not been completed for E1 and E2. Severity: 2 Scope: 3			
1840 SS= F	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care.	1840	1. All clinical team and other appropriate designee staff have completed the required infection control training. 2. Training to be completed by CDC: Project First Line within the scope of unlicensed caregiver infection control on the appriopriate trainings per outlined aboved. 3. All Lumina Employees will have this training completed by August 16th, 2024 and certificates will be maintained and monitored in their employee file. The employees that have been reviewed during this SOD have been completed with their trainings and have been uploaded. 4. ED/WD/designee to ensure all staff have trainings complete by August 16, 2024. 5. August 16, 2024.	08/01/2024

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	Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 3 sampled unlicensed employees received infection control training through a nationally recognized course. (Employees #3, #4, and #5) Findings include: Employee #3 (E3) E3 was hired on 10/25/23 as a Care Specialist. E3's record lacked documented evidence of an annual infection control and prevention training through a nationally recognized course. Employee #4 (E4) E4 was hired on 10/11/23 as a Medication Technician. E4's record lacked documented evidence of an annual infection control and prevention training through a nationally recognized course. Employee #5 (E5) E5 was hired on 12/12/23 as a Care Specialist. E5's record lacked documented evidence of an annual infection control and prevention training through a nationally recognized course. On 06/24/24 in the afternoon, the Executive Director acknowledged E3, E4, and E5 had not received annual infection control and prevention training through a nationally recognized course. Severity: 2 Scope: 3			