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 _____	**03/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINEYARD HENDERSON MEMORY CARE	**2895 W HORIZON RIDGE WAY, HENDERSON, NEVADA ,89052**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey, complaint investigation and Facility Reported Incident completed in your facility on 03/04/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The facility is licensed for 64 Residential Facility for Group beds for Alzheimer's disease, Category II residents. The census at the time of the survey was 58. Sixteen resident files and ten employee files were reviewed. The facility received a grade of A. There was one complaint and one Facility Reported Incidents (FRIs) investigated. Substantiated: 1. Complaint #NV00073176 was substantiated. (See Tag 0966) Substantiated without deficient Practice: 2. FRI# 10913 was substantiated with no deficient practice. The investigation of the Complaint and FRI included: Observations of resident to resident interactions, staffing, medication review, and working phone lines. Interviews were conducted with residents, Caregivers, Medication Technicians, Wellness Director, and the Administrator. Record Review of 16 records, which included the residents of concern. Document Review included facility policy and procedures, incident reports, and staff schedule/census. 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 investigation, 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MAGALI ORTIZ Title: Executive Director Date: 03/23/2025

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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0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 03/04/2025, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the bakery serving kitchen, a package of cookie dough was expired 02/01/25 and two containers of vanilla frosting were expired 11/22/24. 2. Major Violations: a. The floor was soiled with food and debris underneath tables and equipment in the main kitchen. Severity: 2 Scope: 2	0255	1. The identified deficiency has been promptly addressed by removing the bakery refrigerator and discontinuing its use, as it was deemed unnecessary. Additionally, a daily cleaning task sheet has been implemented to ensure thorough cleaning beneath all equipment. 2. In-service training sessions were conducted on March 19, 2025, and March 20, 2025, focusing on Food Safety, Food Expiration Monitoring, and Kitchen Cleanliness. 3. Monitoring procedures will include daily audits to identify and remove expired or unsafe food, ensuring immediate disposal. Additionally, the daily cleaning task sheets will be followed to maintain a clean and debris-free kitchen environment. 4. The individuals responsible for overseeing these corrective actions are the Administrator and the Culinary Director. 5. Supporting documentation will include records of staff training on the relevant policies and procedures. 6. Compliance was achieved and verified on March 20, 2025.	03/20/2025
0966 SS= F	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on	0966	1. The deficiency has been immediately addressed by continuing to follow the the Caregiver/Medtech schedule to meet the 1:6ratio. 2. Systematic changes that will be put in place to ensure deficient practice does not recur:Follow 1:6 ratio making adjustments as needed to cover call off's and open schedules. 3. Monitoring will include internal audits of caregiver/medtech schedules to align with census and 1:6 ratio.	03/20/2025

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	observation, record review, and interview, the facility failed to maintain the required resident to staff ratio during waking hours for an Alzheimer's endorsed facility. Findings include: On 03/04/25 at 9:05 AM, the census at the facility was 58 residents. The facility needed ten staff members to meet the ratio of one staff member for six residents. There were two Medication Technicians (Med Techs) and seven Caregivers on duty which made it a total of nine caregivers on duty. The Caregiver/Med Tech schedules for February 2025-March 2025 were as follows: The AM schedule was from 6:00 AM - 2:30 PM and the PM schedule was from 2:00 PM - 10:30 PM. The following dates were sampled and revealed the following: On 02/03/25 the census at the facility was 56 residents. Ten caregivers were needed to meet the staffing ratio. The PM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/05/25 the census at the facility was 56 residents. Ten caregivers were needed to meet the staffing ratio. The PM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/07/25 the census at the facility was 56 residents. Ten caregivers were needed to meet the staffing ratio. The AM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. The PM shift consisted of eight Caregivers/Med Techs and was short two Caregivers. On 02/09/25 the census at the facility was 56 residents. Ten caregivers were needed to meet the staffing ratio. The AM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/10/25 the census at the facility was 57 residents. Ten caregivers were needed to meet the staffing ratio. The AM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/14/25 the census at the facility was 59 residents. Ten caregivers were needed to meet the staffing ratio. The AM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. The PM shift		4. Titles of those accountable are Administrator and Health and Wellness Director 5. Supporting Documentation will include new caregiver/medtech training on 1:6 ratio and how we will continue to align with current census.	

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	consisted of eight Caregivers/Med Techs and was short two Caregivers. On 02/17/25 the census at the facility was 59 residents. Ten caregivers were needed to meet the staffing ratio. The PM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/21/25 the census at the facility was 60 residents. Ten caregivers were needed to meet the staffing ratio. The PM shift consisted of eight Caregivers/Med Techs and was short two Caregivers. On 02/23/25 the census at the facility was 60 residents. Ten caregivers were needed to meet the staffing ratio. The PM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/24/25 the census at the facility was 60 residents. Ten caregivers were needed to meet the staffing ratio. The PM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/25/25 the census at the facility was 60 residents. Ten caregivers were needed to meet the staffing ratio. The AM shift consisted of eight Caregivers/Med Techs and was short two Caregivers. On 02/26/25 the census at the facility was 60 residents. Ten caregivers were needed to meet the staffing ratio. The AM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. The PM shift consisted of nine Caregivers/Med Techs and was short one Caregiver. On 02/27/25 the census at the facility was 61 residents. Eleven caregivers were needed to meet the staffing ratio. The PM shift consisted of ten Caregivers/Med Techs and was short one Caregiver. On 02/28/25 the census at the facility was 61 residents. Eleven caregivers were needed to meet the staffing ratio. The PM shift consisted of ten Caregivers/Med Techs and was short one Caregiver. On 02/27/25 the census at the facility was 62 residents. Eleven caregivers were needed to meet the staffing ratio. The PM shift consisted of ten Caregivers/Med Techs and was short one Caregiver. On 03/04/25 at 09:13 AM, a Med Tech reported Med Techs were not assigned residents but helped the			

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	Caregivers when they were behind. The Med Tech reported they felt sometimes there wasn't enough staff. Their census could rise quickly, and they did not have enough Caregivers to work. On 03/04/25 at 09:40 AM, a Caregiver reported they worked downstairs and there were currently three Caregivers and one Med Tech for 28 residents and upstairs there were four Caregivers and one Med Tech to 27 residents. The Caregiver often felt there was not enough staff. On 03/04/25 at 11:40 AM, the Wellness Director reported the facility staffed six residents to one Caregiver per the regulation and did not have a specific policy on staffing. On 03/04/25 at 11:55 AM, the Administrator acknowledged they miscalculated the number of caregivers required and did not currently meet the staffing requirement. Severity: 2 Scope: 3 Complaint #NV00073176			

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0994 SS= E	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview the facility failed to ensure sharp objects were secured inside of the memory care unit. Findings include: On 03/04/2025 at 9:24 AM, multiple pairs of scissors and needle nose pilers were observed inside the art studio on the counter located inside of the memory care unit. On 03/04/2025 at 9:30 AM, the Activities Director acknowledged the sharp object were not secured and should have been locked inside of the cabinet. On 03/04/2025 at 9:34 AM, the Wellness Director confirmed the sharp objects were unsecured and should have been in a locked cabinet. Severity: 2 Scope: 2	0994	1. The identified deficiency has been promptly addressed by installing locks on all cabinets in the Art Studio, ensuring that items deemed unsafe for residents are securely stored and inaccessible to them. 2. To prevent recurrence of the deficiency, systematic changes will be implemented, including daily audits to ensure that no hazardous items are left accessible to residents. 3. In-service training sessions were conducted on March 19, 2025, and March 20, 2025, to review the Environmental Safety Policy and Procedures with staff members. 4. Ongoing monitoring will be conducted through internal audits to ensure that all materials are stored in locked cabinets, maintaining their inaccessibility to residents. 5. The individuals accountable for overseeing these measures are the Administrator and the Life Enrichment Director. 6. Supporting documentation will include records of staff training on the relevant policies and procedures. 7. Compliance was achieved on March 20, 2025.	03/20/2025