STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	129	A. BUILDING _____ B. WING _____	01/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS ALZHEIMER AND MEMORY CARE 2	3225 BRAZOS STREET, LAS VEGAS, Nevada ,89169

(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 a complaint investigation in your facility on 1/3/17. This complaint investigation was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, and provides care to persons with Alzheimer's Category II residents. The census at the time of the survey was 10. The sample size was five. There was one complaint investigated. Complaint #NV00047644 was substantiated. The allegation the facility failed to ensure the residents had protective supervision to prevent a resident from eloping was substantiated (See TAGs Y 50, Y 853, Y 992 and Y 997). 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		
0050 SS= F	449.194(1) - Administrator's Responsibilities-Oversight - NAC 449.194 Responsibilities of administrator. 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 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, interview and record review, the administrator failed to ensure a gate leading to an unsecured area was in good repair resulting in a resident eloping (Resident #1). Findings include: On 1/3/17 at 9:45 AM, the gate leading from the front yard/driveway to the back yard was not secured. The gate had a lock built into the gate, however the built in lock was not in	0050	0050 Failed to secure gate leading from the front yard was not secured.Administrator reminded caregiver to ensure that all gates are locked properly using the chain and podlock for the residents safety at all times and never leave the keys hanging in the chain. It will create easy access to elope from the facility. Manager will followup and monitor compliance to prevent from recuring. Done and completed 1/10/2017	01/18/2017

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	working order and a chain with a pad lock were hanging on the gate. A resident's room was located a few feet from the unsecured gate. The resident's room had a door leading from the resident's room to the back yard. On 1/3/17 at 10:00 AM, the caregiver explained they were in a hurry to let the surveyor in the front door and was unable to secure the gate. Resident #1 was admitted to the facility on 6/27/16 with a diagnoses of severe dementia. The Physician's Certificate of Incapacity and Regarding the Need for Guardianship documented the resident needed assistance from wandering off and getting lost, assistance with dressing, preparing meals, toileting functions, hygiene care and financial affairs. On 11/17/16 a local newspaper article documented the resident was last seen around 3:30 AM on 11/17/16, at the home. The resident was located at 1:30 PM by police and brought back to the home the same day. A Release of Medical Assistance form from a local ambulance company dated 11/17/16, documented the house manager explained the resident's family refused medical transport and would follow up with the physician. On 1/3/17 at 10:15 AM, the caregiver explained the police brought the resident back to the facility and called 911 to ensure the resident was not injured. On 1/3/17 at 10:25 AM, the caregiver explained the gate leading from the front yard/drive way to the backyard was not in working order. The gate could be lifted and pushed out towards the driveway. This procedure was demonstrated by the caregiver. This procedure left a large gap between the wall and the gate. The caregiver explained on 11/17/16 Resident #1 eloped from the facility through this gate. The gate had a chain with a padlock. One end of the chain was looped around part of the gate and the other end of the chain was roped around a metal part attached to the wall. The resident was able to lift the chain off the metal part attached to the wall allowing the gate to swing open. The caregiver explained the new procedure to ensure the residents cannot open the gate, was to take the chain, run it through a hole in the metal part and attach the end to the gate, securing the chain with a pad lock.			

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	The key is kept on the block wall by the gate. The caregiver was aware the gate needed to be replaced and explained this was brought to the attention of the owner. On 1/3/17 at 10:30 AM, Caregiver #2 explained On 11/17/16, the caregiver was sleeping and woke up at 3:30 AM to check on the residents and noticed the resident was not in the facility. The caregiver called Caregiver #1 and left a message informing the caregiver the resident had eloped. Caregiver #2 called the police reporting the resident had eloped. Severity: 2 Scope: 3			
0853 SS= D	449.274(3)(a) - Medical Care / Records - 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. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. the record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered. This record must accompany the resident if he is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report was written for a resident's change in condition (Resident #1). Findings include: Resident #1 was admitted to the facility on 6/27/16 with a diagnoses of severe dementia. Resident #1 eloped from the facility on 11/17/16. The residents record lacked documented evidence of an incident report. The facility's incident report log lacked documented evidence of an incident report in regards to Resident #1 eloping from the facility on 11/17/16. On 1/3/16 at 10:15 AM, the caregiver acknowledged the lack of an incident report for the elopement of Resident #1. Severity: 2 Scope: 1	0853	0858 Failed to write an incident report with regards to eloping from the facility. Administrator reminded the care givers/manager to always write an incident report and always inform the authorities and families about the incident. Administrator also reviewed to the caregivers regarding the policy of the facility on elopement. Manager/admininstrator will monitor for compliance to prevent recurrence of the incident. completed and done 1/10/17.	01/18/2017

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0992 SS= F	449.2756(1)(c) - Alzheimer's Fac awake staff - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. Inspector Comments: Based on interview and document, the facility failed to ensure a caregiver was awake at night in an Alzheimer's endorsed facility resulting in a resident eloping (Resident #1). Findings include: On 11/17/16, a local newspaper article documented Resident #1 was last seen at a home at 3:30 AM. The police located the resident at 1:00 PM and returned the resident to the home On 1/3/17 at 10:30 AM, Caregiver #2 explained On 11/17/16, the caregiver was sleeping and woke up at 3:30 AM to check on the residents and noticed the resident was not in the facility. The caregiver called Caregiver #1 and left a message informing the caregiver the resident had eloped. The caregiver then called the police and reported the resident as missing. Caregiver #2 explained they live at the facility. The caregiver works at during the day and at times will work the night shift. The caregiver explained they do not always sleep at night when they are on duty. Severity: 2 Scope: 3	0992	0992 Alzheimer's facility has to hae an awake staff at night.Administrator reviewed the staf schedule of the facility. The facility is well staff on days and night to ensure proper care to the residents. Administrator reminded all the caregivers that they should be awake at all times at night while on duty and ensure all residents are being checked every 2hrs for any changes in condition. Manager/administrator will monitor compliance with regard to this matter to prevent recurrence. Done and completed 1/10/17.	01/18/2017
0997 SS= F	449.2756(1)(f)(3) - Alzheimer's Facility-Yard fenced - NAC 449.2756 Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required; training for employees. 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (3) Is fenced. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure a gate leading to an unsecured area was	0997	0997 The gate leading from the driveway to the backyard was not secured. Administrator instructed all careivers to properly chain and podlock the gate all the time to keep the residents secure. Caregiver verbalized that they forget to secure the chain properly causing the gate to be easily moved and lifted. Administrator discussed about the possibility of changing the gate or fixing it. caregivers demonstrated that gate does not move nor can be lifted up if the gate is properly chained and locked. Manager/ administrator will monitor for compliance to prevent from recurring the same incident. Done and completed 1/10/17.	01/18/2017

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	secured. Findings include: On 1/3/17 at 9:45 AM, the gate leading from the front yard/driveway to the back yard was not secured. The gate had a lock built into the gate, however the built in lock was not in working order . The gate had a chain with a pad lock hanging on the gate. A resident's room was located a few feet from the unsecured gate. The residents room had a door leading from the resident's room to the back yard. On 1/3/17 at 10:00 AM, the caregiver explained they were in a hurry to let the surveyor in the front door and was unable to secure the gate. Resident #1 was admitted on 6/25/16 with a diagnoses of severe dementia. On 1/3/17 at 10:15 AM, Caregiver #1 explained Resident #1 eloped from the facility through the gate on 11/17/16. The caregiver explained the gate leading from the front yard/driveway to the backyard was not in working order. The caregiver demonstrated how the gate could be lifted and pushed out towards the driveway. This procedure left a large gap between the wall and the gate. The gate had a chain with a padlock. One end of the chain was looped around part of the gate and the other end of the chain was roped around a metal part attached to the wall. The resident was able to lift the chain off the metal part attached to the wall allowing the gate to swing open. The caregiver explained the new procedure to ensure the residents cannot open the gate, was to take the chain, run it through a hole in the metal part and attach the end to the gate, securing the chain with a pad lock. The key is kept on the block wall by the gate. The caregiver was aware the gate needed to be replaced and explained this was brought to the attention of the owner. Severity: 2 Scope: 3			