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 _____	**06/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT OF LOVE	**1213 BALZAR AVE, LAS VEGAS, NEVADA ,89106**

(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 the Complaint and Facility Reported Incident Investigation conducted at your facility on 04/28/21 through 06/11/21, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility was licensed for six Residential Facility for Group beds for elderly or disabled persons, with endorsements for mental illness and chronic illness, Category II residents. The census at the beginning of the survey was six. The sample size was three. Two complaints and one facility reported incident were investigated: Complaint #NV00061199 with one allegation was unsubstantiated. Allegation #1: The Owner was named as a beneficiary on a resident's life insurance policy could not be substantiated based on interview with the Owner and the Assistant Administrator, who explained they had not signed as a beneficiary and were not knowledgeable of a life insurance policy for the resident of concern. Record review of the resident of concern documented the life insurance policy was not established during the resident's admission at the facility. Complaint #NV00064058 with two allegations was unsubstantiated: Allegation #1: Resident safety - A resident left the facility, was missing more than 24 hours, and was not reported missing in a timely manner could not be substantiated based on review of facility Incident Reports documenting Missing Person Reports were filed by the facility with the Las Vegas Metropolitan Police Department. Interviews with the Owner and the Assistant Administrator indicated action was taken to attempt to locate the resident, contact the next of kin, and report the resident missing. The Owner and the Assistant Administrator verbalized residents who were alert and oriented were free to go outside of the facility when they wanted. The facility's	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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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	timeline and Incident Report documented the resident of concern's next of kin was notified. Allegation #2: The Owner was set up as a Representative Payee on the resident's Social Security benefits could not be substantiated based on interview with the Owner and the Assistant Administrator, who indicated they did not apply to be a Representative Payee on the resident of concern's Social Security benefits. Record review of the resident of concern lacked evidence the Owner applied to be a Representative Payee with Social Security benefits. Facility Reported Incident #5709 with one allegation was substantiated with no regulatory deficiencies. Allegation #1: A resident was found deceased and had two bags of medications (vitamin supplements) under the bed was substantiated with no regulatory deficiencies identified based on interview with the Caregiver, who indicated the facility's process for admitting residents with belongings included a generalized list of belongings. The facility did not search through resident personal items upon admission when they were alert and oriented, in an effort to respect personal privacy. The resident of concern's roommate verbalized not seeing medications or vitamins with the resident of concern. The Coroner's Office Representative verbalized not having concerns regarding the vitamin supplements and had closed the case. The investigation into the allegations included interviews with the Owner, the Assistant Administrator, two hospital Licensed Social Workers, two Caregivers, and a representative from the Coroner's Office. Record review of three resident records, including the residents of concern. 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			

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	laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.			