Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVADA MEMORY CARE	2299 MONTESSOURI ST, LAS VEGAS, NEVADA ,89117

(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 conducted in your facility on 07/25/18. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer disease, Category II residents. The census at the time of the survey was eight. Eight resident files were reviewed and eight employee files were reviewed. The facility received a grade of B. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVADA MEMORY CARE	2299 MONTESSOURI ST, LAS VEGAS, NEVADA ,89117

(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
0105 SS= D	449.200(1)(f) - Personnel File - Background Check - NAC 449.200 Staffing requirements; limitations on number of residents; written schedule required for each shift. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 8 employees obtained five (5) years fingerprinting renewal on time (Employee #6). Finding include: Employee #6 was hired on 06/23/13 as Caregiver. On 07/25/18 in the morning, reviewing employees file revealed the 5 years fingerprinting was due by 05/24/17 and not completed until 10/16/17, after 5 months later. Severity: 2 Scope : 1	0105	1.) This background check citation fell under the jurisdiction of the previous ADMINISTRATOR. Employee #6 was hired as the new ADMINISTRATOR in September 2017 and immediately sent Employee #7 for a new background check after finding EMPLOYEE #7 was well past due for a background check. Again, there was no way Employee #6 could have corrected this citation (other than sending in Employee #7 in for a background check ASAP) as it was the previous ADMINISTRATOR'S responsibility. 2.) Reviews of employee background check due dates will be done quarterly. 3.) Regular review of employee files and due dates will be performed by Employees #1 and #6. 4.) Administrator will monitor for compliance. 5.) Corrective action completed 7/25/2018.	07/25/2018
0106 SS= D	449.200(2)(a) - Personnel File - 1st aid & CPR - NAC 449.200 Staffing requirements; limitations on number of residents; written schedule required for each shift. 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 8 employees obtained in person cardiopulmonary resuscitation (CPR) (Employee #7). Finding include: Employee #7 was hired 10/01/17 as the Administrator. On 07/25/18 in the morning, Employee #7 file revealed first aid and CPR training was issued from an online course. The Facility Manager said the Administrator did not know that online courses were not acceptanble and must have in person training. Severity: 2 Scope : 1	0106	1.) Administrator will get in-person FIRST AID/CPR training. 2.) All staff first aid/cpr training will be checked to ensure the training was performed in-person. The source/company stated on the training card/certificate will be searched online to see if there is a brick and mortar location for training. 3.) Administrator is now aware that all FIRST AID/CPR training must be done in-person. Administrator will ask the staff members where they received their training and follow up. 4.) Administrator will monitor for compliance. 5.) Corrective action completed 9/8/2018.	09/08/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVADA MEMORY CARE	2299 MONTESSOURI ST, LAS VEGAS, NEVADA ,89117

(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
0178 SS= F	449.209(5) - Health and Sanitation-Maintain Int/Ext - NAC 449.209 Health and sanitation. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on record review and interview, the facility failed to ensure the premises are well maintained. Finding includes: On 07/25/18 at 9:00 AM, the bathroom near room #4 had shower with two decaying holes in the edge of the shower floor. The Manager said, he was not aware the shower floor was damaged and was unaware if the Administrator knew about the damage. It was reported the damage would be repaired. Severity: 2 Scope: 3	0178	1.) Shower floor damage will be repaired and/or replaced. 2.) Staff will be notified to alert head caregiver or administrator of any potential damage or facility repairs needed. 3.) Administrator will speak to staff about the citation and to monitor the facility more closely for potential dangers/risks to resident care. 4.) Administrator will monitor for compliance. 5.) Corrective action completed on 9/22/2018. Shower tile was replaced completely.	09/22/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVADA MEMORY CARE	2299 MONTESSOURI ST, LAS VEGAS, NEVADA ,89117

(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
0940 SS= E	449.2749(1)(g)(3) - Resident file - ADL Evaluation Annually - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure the annual assessment of activity for daily living (ADL) for 2 of 8 residents (Resident #6 and Resident #7). Finding includes: On 07/25/18 in the morning, file review revealed Resident #6 was admitted on 01/02/18. The file lacked documented evidence of a completed ADL assessment. Resident #7 file review revealed an admission date there were no ADL assessment for 2016 and 2017. The facility manager acknowledged there were no documentation of an ADL assessment and said he would update the resident's ADL assessment on the file. Severity: 2 Scope: 2	0940	1.) ADL evaluation will be performed immediately for Resident #6. 2.) All residents will have their ADL's performed roughly around the same time (i.e. in the beginning of the year) so as to make sure ADL's are completed. 3.) Employee #1 will be responsible for completing ADL evaluations for residents. 4.) Administrator will monitor for compliance. 5.) Corrective action completed 7/25/18.	07/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVADA MEMORY CARE	2299 MONTESSOURI ST, LAS VEGAS, NEVADA ,89117

(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
0991 SS= F	449.2756(1)(b) - Alzheimer's Fac door alarm - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises alarms or audible devices are activated when the door was opened. Finding includes: On 07/25/18 at 8:40 AM, observed the facility front door open without the alarm engaged. Employee #1 said the reason the alarm was off, was because it was so loud, and disturbs and scares the residents. At 8:45 AM, on initial tour observation the facility has another two (2) doors toward front yard, one door on the left side and one door on the right side, and when open the alarm did not engaged/ functioning. At 8:55 AM, when Employee #1open the fourth door toward the backyard the alarm did not engaged. The Manager checked the three door alarms and said the alarms were on but not functioning. He said he the batteries will be changed. Severity: 2 Scope: 3	0991	1.) Alarms for the doors specified in the citation will have their batteries changed. 2.) Administrator and Employee #1 will be responsible for maintaining the functional integrity of the door alarms to ensure proper following of the regulation. 3.) Administrator will check each door alarm during each monthly visit, and any visits in-between. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 7/25/18.	07/25/2018