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 _____	**02/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA ESTATE CARE HOME	**3140 COACHLIGHT CIRCLE, 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 a Complaint investigation completed at your facility on 02/02/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 10 Residential Facility for Group beds, with endorsements for persons with mental illness and chronic illness, with five Category I and five Category II. The census at the time of the survey was ten. The sample size was five. The facility received a grade of A. There was one complaint investigated. Complaint #NV00062951 with four allegations was substantiated. The allegation a resident was made to sleep until 7:30 AM each day because caregivers were not awake was substantiated. (See Tag 524) The following allegations could not be substantiated. Allegation #2 - A resident who had diabetes did not receive appropriate types of food to control their blood sugar was unsubstantiated based on interviews with residents and staff members who reported the facility served fruits and vegetables with meals. Observations included fruits and vegetables stored in the refrigerators. Menus were posted documenting fruits and vegetables served with meals. There were no physician orders found recommending a special or diabetic diet in the resident of concern's medical record. Allegation #3 - Residents were not served nutritious meals. Meals served consisted of ramen noodle soup with a sandwich and no variety of vegetables multiple times during the week was unsubstantiated based on observation of two refrigerators which contained a variety of fruits and vegetables, and the lunch meal, which included lasagna, salad and garlic toast. Interviews with residents and staff reported fruits and vegetables were included with meals. Reviewed menus for the months of December 2020, January 2021 and February 2021, which	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SUSAN SOWERS Title: Administrator Date: 02/10/2021

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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	documented a variety of meals served. Allegation #4 -The resident was medicated with a double dose of sleeping medication was unsubstantiated based on observation of five residents who were alert and awake and interviews conducted with four residents who indicated not being overmedicated and a staff member who indicated residents had not been overmedicated. Review of the November 2020 and December 2020 Medication Administration Record (MAR) documented medications were given as prescribed. The investigation into the allegation included: Observation of residents eating lunch, two refrigerators with fresh produce. Interviews with five residents and one Caregiver. Review of five residents' medical records and Medication Administration Records (MARs). Document review of Menus, Admission Agreement and Facility Policies. 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 deficiency was identified:			

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0524 SS= D	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 3. The employees of a residential facility shall: (a) Treat each resident in a kind and considerate manner; and (b) Respect each resident ' s independence and ability to make decisions on his or her own, whenever possible. Inspector Comments: Based on interview, record review and documentation review, the facility failed to ensure three of five residents were allowed out of their rooms before 7:30 AM. Findings include: Resident #1(R1) On 02/02/21 at 10:30 AM, R1 was admitted on 11/25/20, with diagnoses including hypertension and diabetes. R1 verbalized R1 was not allowed to leave the bedroom before 7:30 AM. The resident indicated staff was not awake before 7:30 AM. Resident #2 and Resident # 3, both verbalized they were not allowed to leave their bedrooms before 7:30 AM. On 02/02/21 at 11:30 AM, a Caregiver confirmed residents were asked to remain in their bedrooms until 7:30 AM. The Caregiver verbalized she asked the residents to remain in their bedrooms for their safety. On 02/02/21 at 12:00 PM, the Administrator verbalized a resident was asked to remain in their bedroom until 7:30 AM, due to the resident being a smoker. The Administrator indicated there were safety concerns if the resident went outside to smoke. The Administrator reported she was unaware other residents were asked to remain in their bedrooms before 7:30 AM. The facility policy titled Facility Policies (undated) documented, residents were allowed to rest in their rooms as desired. Severity: 2 Scope: 1 Complaint#NV00062951	0524	Tag 0524 1. The Administrator has informed all residents they have the right to leave bedroom at anytime they like. Residents are also aware there are no restrictions. The employees at Bella Estate was also informed of this. We serve breakfast from 7am -8:30 am. Our meal schedule is posted for residents on the bulletin board. Residents may follow the meal schedule times. (See attachment) 2. The employees will treat each resident in a kind and considerate manner. They will respect each resident's independence and ability to make decisions on their own when possible. 3. On Administrator visit- she will speak to all residents to ensure the deficient practice does not recur. 4. The Administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of Compliance: 02/03/21	02/03/2021