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
	8455	A. BUILDING _____ B. WING _____	01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA OLIVA	3209 CEDAR STREET, LAS VEGAS, NEVADA ,89104

(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 annual State Licensure at your facility on 01/02/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, and/or persons with chronic illnesses, and/or persons with mental retardation, five Category I and four Category II residents. The census at the time of the survey was nine. The facility received a grade of A. 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 deficiencies were identified:	0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8455	A. BUILDING _____ B. WING _____	01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA OLIVA	3209 CEDAR STREET, LAS VEGAS, NEVADA ,89104

(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
0859 SS= E	449.274(5) - Periodic Physical examination of a resident - 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. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 9 residents received an annual physical examination (Resident #5, #7 and #9). Findings include: Resident #5 Resident #5 was admitted on 09/01/16, with diagnoses of schizophrenia. The resident's medical record documented a annual physical examination had been completed on 10/19/16. The resident's medical record lacked documented evidence of an annual physical examination completed in 2017 and 2018. Resident #7 Resident #7 was admitted on 05/26/16, with diagnoses of sclerosis. The resident's medical record documented a annual physical examination had been completed on 11/07/17. The resident's medical record lacked documented evidence of an annual physical examination completed in 2018. Resident #9 Resident #9 was admitted on 12/01/16, with diagnoses including unsteady gait and acquired brain injury (ABI). The resident's medical record documented a annual physical examination had been completed on 11/30/17. The resident's medical record lacked documented evidence of an annual physical examination completed in 2018. On 01/02/19 at 1:00 PM, the Service Supervisor acknowledged all three residents had not received a annual physical examination in 2018. The Service Supervisor indicated it was the facility's error. Severity: 2 Scope: 2	0859	Accessible Space, Inc. policy requires that all residents participate in an annual physical. The new supervisor has been re-trained on this policy and an alert system has been set up electronically to provide reminders of when annual physicals are due for each individual. The agency administrator will also be given electronic alerts and will provide a follow up with the Supervisor to assure that the assessments are completed. Additionally, unannounced Quality Reviews will be completed to monitor completion of all required processes. The Supervisor and Administrator will be responsible for these activities to be completed. All missing physicals will be completed by 1/31/2019.	01/31/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8455	A. BUILDING _____ B. WING _____	01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA OLIVA	3209 CEDAR STREET, LAS VEGAS, NEVADA ,89104

(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
0936 SS= D	449.2749(1)(e) - Resident file-NRS 441A Tuberculosis - 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 9 residents (Resident #7 and #9) completed the required Tuberculosis (TB) Testing. Findings include: Resident #7 Resident #7 was admitted on 05/26/16, with diagnoses of sclerosis. The resident's medical record had evidence of a two step TB test had been completed on 05/26/16, with negative result documented. The resident had a positive TB test in 2017. A chest X-ray was completed on 03/16/17 with a negative result for TB. The resident's medical record lacked documented evidence of a annual screening for signs and symptoms of TB had been completed for 2018. Resident #9 Resident #9 was admitted on 12/01/16, with diagnoses including unsteady gait and acquired brain injury(ABI). The resident's medical record had evidence of a annual TB test completed on 12/02/17, with a negative result documented. The resident's medical record lacked documented evidence of a annual TB test had been completed for 2018. On 01/02/19 at 12:20 PM, a Service Supervisor acknowledged both residents had not completed the required TB testing. The Service Supervisor indicated the TB test should have been completed. Severity: 2 Scope: 1	0936	Accessible Space, Inc. policy requires that all residents participate in an annual TB Screening or Signs and Symptoms Screening if they have had a positive result with X-Ray Clearance in the past. The new supervisor has been re-trained on this policy and an alert system has been set up electronically to provide reminders of when annual TB Tests and Signs and Symptoms are due for each individual. The agency administrator will also be given electronic alerts and will provide a follow up with the Supervisor to assure that the screenings are completed. Additionally, unannounced Quality Reviews will be completed to monitor completion of all required processes. The Supervisor and Administrator will be responsible for these activities to be completed.	01/31/2019