

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA, 89183		
(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 State licensure annual survey conducted in your facility on 01/02/20. This State licensure survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed to provide care to four elderly and/or disabled residents, Category II beds. The census at the time of the survey was three. Three resident files were reviewed and three employee files were reviewed. The facility received a grade of D. 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 deficiencies were identified:	0000		
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on observation and interview, the facility failed to ensure a current staff schedule was posted. Severity: 1 Scope: 3	0088	#0088 The current staff schedule is posted on the wall next to the front door. Administrator and or owner will check weekly to assure the staff schedule is posted. Facility is in compliance as of 01/03/2020.	01/03/2020

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: PARWIN MARCHEWSKI	Title: Owner	Date: 01/15/2020
--	----------------------------	--------------	------------------

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA, 89183		
(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
0102 SS= E	<p>Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee;</p> <p>Inspector Comments: Based on interview and personnel file review, the facility failed to provide annual tuberculosis testing (TB) for two employees (Employee #1 and #2). Severity: 2 Scope: 2</p>	0102	<p>#0102</p> <p>Employee #1 and #2 have received their annual tuberculosis test and the results have been placed in their employee files. Administrator or Owner will monitor each employees file monthly for compliance. 01/17/2020.</p>	01/17/2020
0272 SS= C	<p>Service of Food - Menus - NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to post a current menu. Severity : 1 Scope: 3</p>	0272	<p>#0272</p> <p>The menu is written, planned a week in advance, dated, and posted on the wall next to the front door and kept on file for ninety days. Administrator or Owner will monitor monthly. 01/03/2020.</p>	01/03/2020
0532 SS= C	<p>Activities for Residents - NAC 449.260 Activities for residents. (NRS 449.0302) 1. The caregivers employed by a residential facility shall: (g) Post, in a common area of the facility, a calendar of activities for each month that notifies residents of the major activities that will occur in the facility. The calendar must be: (1) Prepared at least 1 month in advance; and (2) Kept on file at the facility for not less than 6 months after it expires.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure a current activities schedule was posted. Severity: 1 Scope: 3</p>	0532	<p>#0532</p> <p>A current calendar of activities is posted in the facilities common area. The activity schedule is being prepared at least one month in advance and kept on file at the facility for not less than 6 months after it expires. Administrator and Owner will monitor monthly for compliance. 01/03/2020.</p>	01/03/2020

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA ,89183		
(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
0830 SS= D	<p>Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive.</p> <p>Inspector Comments: Based on observation, record review and interview on 01/02/20, the facility failed to obtain a bedfast exemption for Resident #2. Severity: 2 Scope: 1 This is a repeat deficiency from annual inspection on 02/07/19, and re-grading survey from 09/11/19.</p>	0830	<p>#0830 Bedfast exemption paperwork for Resident #2 has been completed and faxed to the Division of Public and Behavioral Health. A copy of the bedfast exemption has also been placed in the Resident's chart. 01/03/2020.</p>	01/03/2020
0876 SS= D	<p>Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met.</p> <p>Inspector Comments: Based on interview and record review, the facility failed to provide a signed ultimate user agreement for the facility to assist with administration of medication for 1 of 3 residents (Resident #3). Severity: 2 Scope: 1</p>	0876	<p>#0876 A signed ultimate user agreement for the facility to assist with administration of medication has been obtained for resident #3. Administrator or owner will check all Resident files for a signed ultimate user agreement. 01/15/2020.</p>	01/15/2020
0878 SS= F	<p>Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the</p>	0878	<p>#0878 Resident #1's Vitamin C, Centrum Silver, and Vitamin D3 are now on sight for the Resident. Resident #2 now has Physician orders documenting medications are to be crushed</p>	01/02/2020

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA, 89183		
(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
	<p>facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.</p> <p>Inspector Comments: Based on observation, interview and record review, the facility failed to ensure 1). Medications were available and on site for 2 of 3 residents (Resident #1 and #3). 2) Physician orders were given as prescribed for 1 of 3 residents (Resident #2) 3). A Medication label prepared by the pharmacy matched the physician order for 1 of 3 residents (Resident #3). Findings include: Resident #1 (R1) R1 was admitted on 08/16/18, with diagnoses including debility and anxiety. On 1/2/20 at 9:00 AM, R1's prescribed medications - Vitamin C, Centrum Silver and Vitamin D3 were not available on site. The Caregiver confirmed the</p>		<p>in to liquid or sauce.</p> <p>Resident #3's Lisinopril bottle is now available on sight. Administrator or owner will monitor</p> <p>monthly to ensure each Resident's Physician medication list match the labels on the Patient's</p> <p>medication bottles. 01/02/2020.</p> <p>Resident #3's Acetaminophen Physician order has been corrected to Acetaminophen 325mg take</p> <p>two tabs by mouth two times a day daily as needed for Pain. The label on Resident #3's</p> <p>medication bottle has been corrected so that it matches the Physician order.</p> <p>Administrator or</p> <p>owner will monitor monthly to ensure each Resident's Physician medication list match the labels</p> <p>on the Patient's medication bottles.</p> <p>01/02/2020.</p>	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA, 89183		
(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
	medications were not available. Resident #2 (R2) R2 was admitted on 08/23/19, with diagnoses including hypertension and Parkinson's Disease. R2 was prescribed the following medications: - Carbidopa/Levodopa 25/100 milligrams (mg), take one tablet three times a day orally. -Lisinopril 20 mg tablet, take one tablet by mouth daily. R2's December 2019 MAR documented to crush both medications into liquid or sauce. There were no Physician orders documenting medications were to have been crushed into liquid or sauce. Resident #3 (R3) R3 was admitted on 11/15/19 with a diagnosis of osteoarthritis. On 01/02/20, R3's prescribed medication, Lisinopril was not available on site. The Caregiver confirmed the medications were not available. R3 was prescribed Acetaminophen 325 mg, take two tablets by mouth twice daily. The label on the medication bottle documented take two tablets by mouth as needed. The Caregiver confirmed the label on the medication bottle and physician order did not match. Severity: 2 Scope: 3			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA ,89183		
(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
0895 SS= F	<p>Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician.</p> <p>Inspector Comments: Based on observation, record review and interview, the facility failed to ensure the medication administration record (MAR) was accurate and complete for 3 of 3 residents. There was no evidence a MAR had been created and/ or completed for the months of December 2019 and January 2020.</p> <p>Severity: 2 Scope: 3</p>	0895	<p>#0895</p> <p>The missing Medication Administration Records for December and January have been located and placed in each Resident's charts. Administrator or owner will monitor monthly to ensure each Resident's MAR is on file in the medication book. 01/03/2020.</p>	01/03/2020

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA ,89183		
(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
0920 SS= F	<p>Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected.</p> <p>Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident's medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured. During a tour of the facility a medication cabinet was unsecured and not locked. Severity: 2 Scope: 3</p>	0920	<p>#0920</p> <p>The locks have been replaced and facility charts and medications are now properly secured.</p> <p>Owner will monitor daily to ensure that the Resident's charts and Medications are secured.</p> <p>01/15/2020.</p>	01/15/2020

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA, 89183		
(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
0923 SS= D	<p>Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered.</p> <p>Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure a medication (Fluticasone Propionate) was kept in the original container provided by the pharmacy with a prescription label and a medication (Aspirin) was labeled with the name of the resident and the physician for 1 of 3 residents (Resident #1). Severity: 2 Scope: 1</p>	0923	<p>#0923</p> <p>The facility has ensured a medication Fluticasone Propionate is now being kept in the correct container and on sight. The Medication Bottle for Aspirin was labeled with the name of the</p> <p>Resident and the Physician. Each Resident's MARs will be checked monthly by the</p> <p>Administrator/Owner. 01/15/2020.</p>	01/15/2020
0930 SS= F	<p>Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident's allergies, if any, and any special diet or medication he or she requires.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure medical records for 3 of 3 residents were secured. Resident files were observed in an unlocked cabinet. Severity: 2 Scope: 3</p>	0930	<p>#0930</p> <p>Locks have been replaced and all Resident Files are secured. Owner will ensure that Resident</p> <p>Files are secured at all times with locking key. 01/15/2020.</p>	01/15/2020

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA ,89183		
(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= E	<p>Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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.</p> <p>Inspector Comments: Based on interview and record review, the facility failed to ensure initial two-step tuberculosis testing was completed and documented for 2 of 3 residents (Resident #2, #3). Severity: 2 Scope: 2</p>	0936	<p>#0936</p> <p>Resident #2 and Resident #3 have completed their initial two-step tuberculosis testing and it was documented. Copies have been sent to the DPBH. The Administrator and owner will monitor</p> <p>Resident's charts monthly for current TB testing results. 01/15/2020.</p>	01/15/2020

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/02/2020
NAME OF PROVIDER OR SUPPLIER SHINY STARS HOME CARE II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 SILVER CREEK, LAS VEGAS, NEVADA, 89183		
(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
0938 SS= D	<p>Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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 or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year.</p> <p>Inspector Comments: Based on interview and record review, the facility failed to ensure an activities of daily living screening was completed upon admission for 1 of 3 residents (Resident #3). Severity: 2 Scope: 1</p>	0938	<p>#0938</p> <p>An Activities of Daily Living Assessment has been completed for Resident #3 and placed in the Resident's file. Administrator and owner will monitor each Resident's chart to ensure that they have an Activities of Daily Living Assessment form in the Resident File.</p> <p>01/15/2020.</p>	01/15/2020