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 _____	**03/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VITA CARE HOME	**9924 WONDERFUL DAY DRIVE, LAS VEGAS, NEVADA ,89148**

(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 conducted at your facility on 03/25/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. The sample size was five. The facility received a grade of A. There was one complaint investigated: Substantiated: 1. Complaint #NV00070685 was substantiated. (See TAG Y0967) The investigation of the Complaint included: Observation of grooming and physical appearance for residents, residents receiving care and assistance, resident rooms, alarms on doors, locks on the backyard gate, and tour of the facility. Interviews were conducted with residents, the residents of concern, a Caregiver, a Med Tech and the Owner. Clinical Record Review of 5 records, which included the residents of concern. Five employee files were reviewed. Document review included facility policy and procedures, and admission documents. 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		
0967 SS= H	Alzheimer’s Care - NAC 449.2754 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of	0967	**A. As the new administrator, alarms were checked at all exits and ensured that the alarms are replaced with new batteries and are operational. Signages were also installed by the exits to inform visitors to deter elopement. Comprehensive training on elopement**	04/24/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: GINALYN BALTAZAR Title: Administrator Date: 04/29/2024

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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	the facility a written statement which includes: (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behavior will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; Inspector Comments: Based on observation, document review, record review and interview the facility failed to provide protective supervision to two residents who eloped from the facility. (Resident #1 and Resident #2). Findings include: Resident #1 (R1) R1 was admitted to the facility on 12/14/22 with a diagnosis of Alzheimer's disease. Resident #2 (R2) R2 was admitted to the facility on 11/15/23 with a diagnosis of neurocognitive disorder. A Facility Incident Report dated 02/18/24 at 7:05 AM documented R1 and R2 eloped from the facility around 12:00 AM on 02/18/24. R1 and R2 jumped up and off the gate and left the facility while Employee #3 (E3) was assisting another resident. The residents were found at a neighbor's house and the neighbor called the police. The police knocked on the door of the facility to return the two residents and to report the incident of elopement. Record review revealed there was no documented evidence E3 contacted R1 and R2's physician or responsible party following the incident of elopement. A Facility Separation Form dated 02/18/24 documented E3 was terminated from the facility for unsatisfactory performance, dishonesty, and a violation of company policy and		**and wandering policies and procedures was conducted for all current employees.** **B. A routine safety check log was provided to the employees to check each residents every 2 hours for safety and monitoring.** **C. Complete Date: 04/01/2024** **D. SEE TAG 0967**	

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	procedure. Additionally, the Separation Form documented E3 admitted to turning off the alarm to the front door prior to the incident of elopement. On 03/25/24 in the afternoon, the Owner was interviewed and confirmed R1 and R2 eloped from the facility because E3 was the sole caregiver and was asleep during the incident. E3 was not alerted to the door opening because E3 had turned the door alarm off. R1 and R2 went to the neighbor's yard and the neighbor contacted the police. The police knocked on the facility's door and it additionally took some time for E3 to answer the door. The Owner indicated when a resident elopes, the process was for the facility to reach out to the resident's physician and responsible party as soon as possible. The Owner acknowledged E3 did not immediately contact the physician or the responsible parties for R1 and R2 and should have. The Owner reported E3 did not follow the facility's procedures and was immediately terminated. On 03/25/24 in the morning, the Medication Technician (Med Tech) reported R1 and R2 eloped from the facility on 02/18/24 and were found in the neighbor's yard. The Med Tech reported E3 did not contact R1 and R2's physician or responsible party once R1 and R2 returned to the facility. The Med Tech explained it was each employee's responsibility to immediately contact the authorities, the physician, the resident's responsible party, the Administrator, and the Owner when a resident eloped. The Med Tech reported employees were trained on this process and procedure in the training provided by the facility. On 03/26/24 in the afternoon, R1's responsible party confirmed not being contacted by the facility regarding the incident of R1's elopement. R1's responsible party verbalized being notified by the police that R1 had eloped from the facility. A Resident Admissions Agreement documented the facility's policy was for supervision to be provided on a twenty four hour basis in the facility and routine safety			

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	checks would be made by staff. Severity: 3 Scope: 2 Complaint# NV00070685			