

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8720	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2018
NAME OF PROVIDER OR SUPPLIER KIND HEARTS CARE HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 386 SEVERN CT, HENDERSON, NEVADA ,89002		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 01/12/18. 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 seven 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 five. Five resident files were reviewed and six 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 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:			
0072 SS= D	449.196(3)(a-c) - Qualifications of Caregiver-Med Training - NAC 449.196 Qualifications of caregivers. 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.037, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of	0072	449.196(3)(a-c)-Qualifications of Caregiver-Med Training - NAC 449.196 Qualifications of Caregivers. SS=D 0072 1. Corrective action for the caregiver/employee affected by the alleged deficient practice: Employee #5 was hired on 08/14/2017 with only 8 hour of medication management training was completed. The employee involved was educated by the Administrator as to the importance of attending the Medication Administration training as required under paragraph (e) of subsection 6 of NRS 449.037 which must include 16 hours of training in the management of medication. The employee affected by the alleged deficient practice just submitted 8 hours of training, initial training was taken in California. Employee #5 took Medication Administration training on 01/21/2018 and	01/21/2018

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 Name: MARILOU CAYANAN Title: OWNER & MANAGER
REPRESENTATIVE'S SIGNATURE

Date: 02/25/2018

Division of Public and Behavioral Health

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	NAC 449.2742; and Inspector Comments: Based on observation, record review and interview, the facility failed to ensure 1 of 6 employees completed the initial 16 hours of medication management training as required in NRS 449.037(6) (Employee #5). Findings include: Employee #5 was hired on 08/14/17. A record review of the employee file revealed eight hours of medication management was completed . The file lacked documented evidence for the completion of 16 hours of medication management training. On 01/12/18 at 11:45 AM, the Employee confirmed eight hours of training was completed. Severity: 2 Scope: 1		completed the 16 hours of training. Certificate of Completion is hereto attached. 2. Measures/systemic changes put in place to ensure the alleged deficient practice does not recur: The Administrator and Owners shall see to it that all the basic requirements before hiring an employee will be completed prior to start of work. No caregiver is allowed to assist a resident in the administration of medication without receiving the required number of training hours in medication management. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and Owners will conduct a periodic audit of the employee records to ensure documentations completed. 4. The Administrator and Owners are re the responsible persons in ensuring that plan of corrected is implemented. 5. Corrective action was completed on 01/21/2018.	
0085 SS= F	449.199(1) - Staffing-CG on duty all times - NAC 449.199 Staffing requirements; limitations on number of residents; written schedule required for each shift. 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. Inspector Comments: Based on record review, interview and observation, the administrator failed to ensure a caregiver was on duty to provide care for 5 of 5 residents. Findings include: On 01/12/18 at	0085	449.199(1) - Staffing-CG on duty all times - NAC 449.199 Staffing requirements. SS=F 0085 1. Corrective action for the employee found to be affected by the alleged deficient practice: Employee #6 found to be present at the facility without employee file. The facility has 5 employees assigned on a shifting basis. Employee #5 was the assigned caregiver on 01/12/2018 but had an emergency and excused herself for 3 hours. Employee #6 was requested to step in. Employee #6 was not hired because the facility has already	01/12/2018

Division of Public and Behavioral Health

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	9:00 AM, a caregiver (Employee #6) greeted the survey team and provided a tour of the facility. There were no other caregivers present in the facility. The individual was familiar with the facility, provided information about the residents, located the Medication Administration Record (MAR), and unlocked the cabinet containing resident medications. A review of the employee files revealed the caregiver lacked an employee file. There was no indication if the caregiver obtained the necessary pre-employment physical, was tested for tuberculosis, completed the required training, or underwent a criminal background check. On 01/12/18 at 11:45 AM, the Owner indicated the caregiver was not an employee and did not have an employee file. The individual was asked to step in on this day due to the emergency of another employee. Severity: 2 Scope: 3		enough caregivers. The Administrator reprimanded and educated Employee #5 that said instance will not happen again. Employee #5 should inform the Administrator and Owners for any case of emergency so as proper re-shifting can be made. 2. Measures/systemic changes put in place to ensure the alleged deficient practice does not recur: The Administrator and Owners will not allow a step in or temporary employee. There will be a daily monitoring of the activities of the employees assigned during the shift. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and Owners will conduct a random audit of the activities of the employees to ensure that employees assigned during the shift provides the right care and protective supervision for the residents. There will be always 2 employees to be assigned every shift. 4. The Administrator and the Owners are the responsible persons in ensuring that plan of correction is implemented. 5. Corrective action was completed on 01/12/2018.	

Division of Public and Behavioral Health

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(X4) ID PREFIX TAG 0103 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 449.200(1)(d) - Personnel File - NAC 441A / Tuberculosis - 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees (Employee #5) had documented evidence of an annual tuberculosis (TB) test. Findings include: Employee #5 was hired on 08/14/17. The personal file contained a Quantiferon blood test dated 11/09/16. The personal file lacked documented evidence of annual 2017 TB test. On 01/12/18 at 11:30 AM, the employee could not remember if an annual 2017 TB test was obtained, and could not provide documented evidence a test was completed. Severity: 2 Scope: 1	ID PREFIX TAG 0103	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 449.200(1)(d) - Personnel File - NAC 441A/Tuberculosis SS=D 0103 1. Corrective action for the employee found to be affected by the alleged deficient practice: Personnel #5 file lacked documented evidence of annual 2017 TB test. TB test of Employee #5 was incorporated in the report of physical examination. Attached is a copy of the annual physical examination of employee #5. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and Owners will see to it that all documentary requirements in the hiring of employees are present during hire and to be renewed annually. 3. Corrective actions will be monitored to ensure that alleged deficient practice will not recur: The Administrator and Owners will conduct a periodic audit of the employees file to ensure documentation completed. 4. The Administrator and Owners are the person responsible in ensuring plan of correction is implemented. 5. Corrective action completed on 01/12/2018.	(X5) COMPLETION DATE 01/12/2018

Division of Public and Behavioral Health

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(X4) ID PREFIX TAG 0105 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 6 employees met criminal background check requirements of NRS 449 (Employee #2). Findings include: The Administrator was hired on 01/05/17. The employee file contained documentation for a background check from another facility. On 01/12/18 at 11:30 AM, The facility was unable to provide documentation indicating the Administrator underwent a background check before being employed by the facility. Severity: 2 Scope: 1	ID PREFIX TAG 0105	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 449.200(1)(f) - Personnel File - Background Check SS=D 0105 1. Corrective action for the employee found to be affected by the alleged deficient practice: Employee # 2 failed to undergo a background check with the facility. Background check on file was from another facility. The owners required employee #2 to undergo background check in compliance with NRS 449.176 TO 449.185, inclusive. Attached are copies of the background check, final registry result and notification of clearance. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Owners will see to it that background check and other required documentary requirements before hire are complete and filed in a personnel file. 3. Corrective actions will be monitored to ensure alleged deficient practice will not recur: The Owners will conduct a periodic audit of all personnel file to ensure documentations completed. 4. The Owners are the responsible persons in ensuring plan of correction is implemented. 5. Corrective action was completed on 01/18/2018.	(X5) COMPLETION DATE 01/18/2018

Division of Public and Behavioral Health

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(X4) ID PREFIX TAG 0106 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 6 employees were trained in cardiopulmonary resuscitation (CPR) (Employee #4). Findings include: Employee #4 was hired on 01/05/17. On 1/12/18 at 11:00 AM, a review of the employee file revealed CPR training was completed online and did not include chest compression component. On 01/12/18 at 11:00 AM, Employee #4 confirmed the finding. Severity: 2 Scope: 1	ID PREFIX TAG 0106	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 449.200(2)(a) - Personnel File - 1st Aid & CPR SS=D 0106 1. Corrective action for the employee found to be affected by the alleged deficient practice: Employee #4 was hired On 01/05/17 but CPR training was completed on line and did not include chest compression component. The Administrator discussed and educated the employee about the importance of following the requirement as mandated in NAC 449.200. The Administrator required the employee to attend CPR training. Employee #4 attended and completed the CPR training on 01/18/2018. Copy of the CPR training completion is hereto attached. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and Owners will see to it that all the required documentary requirements before hire will be completed. Employee cannot start shift without completing all the basic trainings as required by the state. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and Owners will conduct a period audit of the employees records and file to ensure documentation completed. 4. the Administrator and Owners are the person responsible for ensuring plan of correction is implemented. 5. Corrective action was completed on 01/18/2018.	(X5) COMPLETION DATE 01/18/2018
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	0178	449.209(5) - Health and Sanitation-Maintain Int/Ext SS=F 0178	01/13/2018

Division of Public and Behavioral Health

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	premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were clean and well maintained. Findings include: On 01/12/18 at 9:30 AM, a tour of the facility revealed the following: -Both resident bathrooms had hair lint, and a black mold-like substance accumulating underneath the shower mats. -Used toilet paper was being disposed in the trash can in the hallway resident bathroom. On 01/12/18 at 9:45 AM, a Caregiver acknowledged the showers required further cleaning and reported residents were asked to throw used toilet paper in the trash can because the toilet recently clogged. Severity: 2 Scope: 3		1. Corrective action for the facility found to be affected by the alleged deficient practice: Both resident bathrooms had hair lint and a black mold substance accumulating underneath the shower mats and used toilet paper was being disposed in the trash can in the hallway resident bathroom. The Administrator discussed the alleged deficient practice with the Owners and Caregiver. She emphasized about health and sanitation which is the basic requirement by the state. Facility premises should be clean inside and out. The Administrator conducted an in-service training on how to clean inside and outside premises for both caregivers and owners. She emphasized that cleaning should be done on a daily basis and as needed. Caregivers and Owners cleaned all the three (3) bathrooms of the facility and the rest of the interior and exterior areas of the facility. Regarding toilet paper being disposed in the trash can in the hallway resident bathroom, the Administrator discussed the alleged deficient practice to the residents and called the attention of the owns and Caregivers to monitor compliance of the residents. Attached are the pictures of the bathrooms and other areas of the facility that were cleaned. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and Owners will check the interior and exterior areas of the facility as to its cleanliness on a daily basis. Caregivers to check trash cans in all the bathroom and see if residents comply with what has been told that toilet paper should be disposed in the toilet bowl and not in the trash can. The Owners will check all the bathroom in a daily basis and see to it that shower mats	

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			has no lint and molds. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and Owners will conduct daily monitoring of the cleanliness of the facility to ensure compliance. Residents activities are also to be checked on a daily basis as to the disposal of toilet papers. 4. The Administrator and Owners are the person responsible for ensuring the plan of correction is implemented. 5. Corrective action was completed on 01/13/2018.	
0250 SS= F	449.217(1) - Kitchens-Equipment works; Clean and Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation and interview, the facility failed to ensure food was thawed appropriately. Findings include: On 01/12/18 at 9:10 AM, the following food items were found thawing in the windowsill of the kitchen: -one package of turkey franks -two Ziploc baggies of hamburger -one chicken breast -one Ziploc bag of bacon On 01/12/18 at 9:10 AM, a Caregiver confirmed the items should be thawed in the microwave and not left out at room temperature. Severity: 2 Scope: 3	0250	449.217(1) - Kitchens-Equipment works, Clean and Sanitary SS=F 0250 1. Corrective action for the facility found to be affected by the alleged deficient practice: Facility failed to ensure food was thawed appropriately. The Administrator discussed and educated the Owners and Caregivers as to the proper thawing of food and that is: in a refrigerator, under cold running water, in a microwave or part of the cooking process. The Administrator showed demonstration how to thaw food. The Administrator emphasized never to put food in the windowsill of the kitchen. Further emphasized that the kitchen and the equipment must be clean and must allow for the sanitary preparation the food. Attached is the picture of the cleaned windowsill. 2. Measures/systemic change put in place to assure the alleged deficient practice does not recur: The Administrator and the Owners will check daily the kitchen activities of the Employees in-charge of the kitchen. An in-	01/13/2018

Division of Public and Behavioral Health

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			service training will be conducted to all employees especially to a new employee on a weekly basis as to the maintenance of cleanliness of the kitchen and equipment and that all equipment must be in good working condition. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and the Owner will conduct a daily monitoring of the Caregivers/employees activities especially in the preparation of food. No employees will be assigned in the kitchen not unless an in-service is being made. 4. Person responsible for ensuring plan of correction is implemented: The Administrator and the Owners are the responsible persons in ensuring that plan of correction is implemented. 5. Corrective action was completed on 01/13/2018. ensure that	

Division of Public and Behavioral Health

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(X4) ID PREFIX TAG 0876 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 449.2742(4) - Medication Administration NRS 449.0302 - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. 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 controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure an Ultimate User Agreement to manage resident medications was obtained for 1 of 5 residents (Resident #2). Findings include: Resident #2 was admitted on 12/30/17. The resident file lacked documented evidence of a signed agreement for the facility to manage and administer the resident's medications. On 01/12/18 in the morning, the Owner was unable to provide the documented evidence. Severity: 2 Scope: 1	ID PREFIX TAG 0876	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 449.2742(4) - Medication Administration NRS 449.0302 - NAC 449.2742 Administration of medication SS=D 0876 1. Corrective action for the facility found to be affected by the alleged deficient practice: Based on record review and interview, the facility failed to ensure an Ultimate User Agreement to manage resident medications was obtained for Resident #2. The Administrator and Owners did a file review after Facility Inspectors left and found out that the Ultimate User Agreement/Release of Medication Management Agreement for Resident #2 was just misfiled, hence, not found in Resident #2 records. The Administrator discussed and education the Owners and Employees as to the proper filing of records, that there should be a presence of mind in working and to stay focus with their job. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator with the help of the Owners has to review resident files at the time of admission, seeing to it that all the required documents are in its proper place. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and Owners shall conduct a periodic audit of resident records to ensure documentations completed. 4. Persons responsible for ensuring plan of correction is implemented: The Administrator and the Owners are the responsible persons in ensuring plan of correction is implemented. 5. Corrective action was completed on 01/12/2018.	(X5) COMPLETION DATE 01/12/2018

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(X4) ID PREFIX TAG 0878 SS= E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NAC 449.2742(5)(6) - Medication / OTCs, Supplements, Change Order - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers 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 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 (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. Inspector Comments: Based on record review and interview, the facility failed to ensure medications for 2 of 5 residents were on site. This resulted in residents missing medication doses (Resident #3 and #4). Findings include: On 01/12/18 at 1:00	ID PREFIX TAG 0878	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Supplemental Change Order - NAC 449.2742 Administration of medication: responsibilities of Administrator, Caregivers and Employees of facility. SS=E 1. Corrective action for the facility found to be affected by the alleged deficient practice: The facility failed to ensure medications for 2 of 5 residents were on site. This resulted in residents missing medication doses (Resident #3 and #4). The Administrator discussed with the Owners and Caregivers about the deficiency and educated Owners and Caregivers about the importance of the medication administration record. All medications (regular/over the counter) should have an MD order/prescription script. Any new/changed/discontinued medications should have an MD order/prescription script. Prescription refill should be coordinated with the pharmacy within 7 days before medication run out. Attached are the medications in question and the reason for not on site. 1) Magnesium 250mg 1 tab by mouth once daily after dinner - Called the Pharmacy several times and also MD clinic, awaiting MD authorization for the refill - Received an MD order from the clinic that magnesium should be discontinued - Copy of the MD order is hereto attached 2) Senna Docusate Sodium 8.6mg 1 tab by mouth twice daily - Called the Pharmacy and MD clinic several times, awaiting MD authorization for the refill - Refill was received on 01/15/2018 - Copy of the receipt is hereto attached 3) Tylenol 500mg 1 tab by mouth	(X5) COMPLETION DATE 02/12/2018

Division of Public and Behavioral Health

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	PM, the following medications were observed not on site: Resident #3 - Magnesium 250 milligrams (mg) take one tablet once daily after dinner. The medication had not been given since 01/9/18. Resident #4 - Senna Docusate Sodium 8.6 mg, take one tablet by mouth twice a day. The medication had not been given since 01/1/18 in the morning. - Zolpidem extended release 12.5 mg take one tablet by mouth at bedtime as needed. - Tylenol 500 mg, take one tablet by mouth every six hours as needed for pain. On 01/12/18 at 1:00 PM, a Caregiver confirmed the medications were not on site. Severity: 2 Scope: 2		every 6 hrs as needed for pain - Called the Pharmacy and MD clinic several times, awaiting MD authorization for the refill - Refill was received 02/12/2018 - Copy of the MD order and receipt is hereto attached 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and the Caregivers designated in the medication administration will check the medication administration record on a daily basis as to any new/changed/discontinued medications. An in-service training was conducted by the Administrator. It was emphasized during the in-service training that 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 facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be included in the record. Further, All medications 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, the Caregiver responsible for assisting in the administrations of the medication shall; comply with the order, indicate in the container of the medication that a change has occurred and note the change in the medication administration record. 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. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator will audit the	

Division of Public and Behavioral Health

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			medication administration record periodically to ensure documentations completed. 4. Person responsible in ensuring plan of correction is implemented: The Administrator, Owners and Employees in charge in the medication administration are the persons responsible in ensuring plan of correction is implemented. 5. Corrective action was completed on 02/12/2018.	

Division of Public and Behavioral Health

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NAME OF PROVIDER OR SUPPLIER KIND HEARTS CARE HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 386 SEVERN CT, HENDERSON, NEVADA ,89002		
(X4) ID PREFIX TAG 0991 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 alarms for 2 of 2 exit doors were functional when the door was opened. Findings include: On 01/12/18 at 9:06 AM, upon entry to the facility, the front door and the back patio sliding glass door alarms were observed turned off. On 01/12/18 at 9:06 AM, a Caregiver confirmed the alarms were turned off. Severity: 2 Scope: 3	ID PREFIX TAG 0991	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 449.2756(1)(b) - Alzheimer's Fac door alarm - NAC 449.2756 SS=F 0991 1. Corrective action for the facility found to be affected by the alleged deficient practice: Facility failed to ensure alarms for 2 of 2 exit doors were functional when the door was opened. The Administrator conducted a group meeting with the Owners and Caregivers and educated them as to the importance of NOT turning off door alarms. It was emphasized during the meeting that under state regulations for a facility licensed to provide care to persons with Alzheimer's disease; operational alarms, buzzers, horns or other audible devices should be activated at all times when door is opened. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and the Owners are to check daily for door alarms to be working at all times. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and the Owners are to check daily whether or not door alarms are working to ensure compliance of the regulations. 4. Persons responsible in ensuring plan of correction is implemented: The Administrator and the Owners are the persons responsible in ensuring plan of correction is implemented. 5. Corrective action is completed on 01/12/2018.	(X5) COMPLETION DATE 01/12/2018
0994 SS= F	449.2756(1)(e) - Alzheimer's facility - Dangerous items - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's	0994	449.2756(1)(e) - Alzheimer's facility - Dangerous items - NAC 449.2756 SS=F 0994	01/13/2018

Division of Public and Behavioral Health

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	disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure dangerous items were secured. Findings include: On 01/12/18 at 9:05 AM, knives and scissors were observed in an unlocked kitchen cabinet. The key to the cabinet was left in the lock. Nail clippers and scissors were found unsecured in the second resident room (on the right side of the hallway). On 01/12/18 at 9:30 AM, a Caregiver acknowledged the unsecured items in the unlocked cabinet and resident bedroom. Severity: 2 Scope: 3		1. Corrective action for the facility found to be affected by the alleged deficient practice: Facility failed to ensure dangerous items were secured. Knives and scissors were observed in an unlocked kitchen cabinet. the key to the cabinet was left in the lock. Nail clippers and scissors were found unsecured in the second resident room. The Administrator conducted meeting and educated the Owners and Caregivers as to the importance of keeping knives and other items that could constitute danger to the residents to be placed in a locked cabinet and are inaccessible to the residents. The Administrator emphasized that under state regulations for facility to provide care to person with Alzheimer's disease to ensure that sharp objects are inaccessible to residents. Attached are pictures showing that sharp objects are places inside locked cabinet which includes clippers and scissors. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and the Owners are to check on a daily basis that all sharp objects were placed inside a locked cabinet. All resident rooms are also to be checked ensuring that no clippers/scissors/sharp objects are inside their rooms. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and the Owners shall conduct inspection on a daily basis to ensure compliance that all sharp objects were placed inside a locked cabinet inaccessible to the residents. 4. Persons responsible for ensuring plan of correction is implemented: The Administrator and the Owners are the persons responsible in ensuring	

Division of Public and Behavioral Health

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			compliance of the regulations. 5. Corrective action is completed on 01/13/2018.	
0999 SS= F	449.2756(1)(g) - Alzheimer's Facility-Toxic substances - NAC 449.2756 Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required; training for employees. 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic items were not accessible to residents. Findings include: On 01/12/18 at 9:30 AM, a tour of the facility revealed the following: - One bottle of Muriatic acid, one bottle of Clorox bleach, one bottle of toilet bowl cleaner, and one bottle of Mr. Clean multipurpose cleaner were found unsecured in a plastic tub on the back patio. - Lysol spray was found unsecured in a closet that was storing linens and a second container of spray was found unsecured in a cabinet in the bathroom. - Liquid laundry detergent and Clorox bleach for colors were found unsecured on a shelf above the washer and dryer. - Paint thinner was found in an unlocked cabinet under the sink and multiple cleaning products were found in another unlocked cabinet in the kitchen. On 01/12/18 at 9:45 AM, a Caregiver acknowledged the observations. Severity: 2 Scope: 3	0999	449.2756(1)(g) - Alzheimer's Facility - Toxic substances - NAC 449.2756 SS=F 0999 1. Corrective action for the facility found to be affected by the alleged deficient practice: A tour of the facility revealed that one bottle of muriatic acid, one bottle of Clorox bleach, one bottle of toilet bowl cleaner and once bottle of Mr. Clean multipurpose cleaner were found unsecured in a plastic tub on the back patio, Lysol spray were found unsecured on a shelf above the washer and dryer, multiple cleaning products were found in another unlocked cabinet in the kitchen. The Administrator conducted a meeting with the Owners and Caregivers and educated them about the importance of keeping safe all toxic substances, that they should not be accessible to the residents of the facility. The Administrator showed a place where all toxic substances has to be placed. Employees were required to clean inside and outside areas, seeing to it that all toxic substances are stored in a locked cabinet. Pictures of the cabinets and outside cleaned areas are attached to show corrective actions were made. 2. Measures/systemic changes put in place to assure the alleged deficient practice does not recur: The Administrator and Owners will check the facility on a daily basis, ensuring all toxic substances are in a locked cabinet and that the facility is clean both inside areas	01/13/2018

Division of Public and Behavioral Health

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			and outside areas. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Administrator and Owners will conduct a daily inspection to ensure compliance of the state regulations that all toxic substances are in a locked area and are not accessible to the residents of the facility. 4. Persons responsible for ensuring plan of correction is implemented: The Administrator and the Owners are the persons responsible in ensuring plan of correction is implemented. 5. Corrective action was completed on 01/13/2018.	