

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 A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/09/2024
NAME OF PROVIDER OR SUPPLIER  RAINBOW ADULT CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1823 BELCASTRO STREET, 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 an annual State Licensure and Complaint Investigation survey completed at your facility on 01/09/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly or disabled persons and/or persons with chronic illness and/or mental illness, six Category II residents and four Category I residents. The census at the time of survey was 10. Eleven resident files and four employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Unverified: Complaint #NV00069772 could not be verified. No regulatory deficiencies could be identified. The investigation of the complaint include: Observation of resident's hygiene, lack of odors, appropriate staff and resident interactions, residents on appropriate oxygen levels per physicians orders, beds functioning properly and no residents in pain. Interviews were conducted with residents, a Caregiver and the Administrator. Clinical Record Review of 11 records, which included the resident of concern. Document Review including incident reports, staff records and facility policy on pain management. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: FAITH SHARI RAMOS Title: Administrator  
 REPRESENTATIVE'S SIGNATURE

Date: 01/25/2024

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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0620 SS= D	<p>Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis.</p> <p>Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a waiver, to retain a resident who is bedfast, for 1 of 10 residents (Resident #4). Findings include: Resident #4 (R4) was admitted on 05/30/23 with diagnosis including seizure disorder and hypertension. On 01/09/24 in the morning, R4 was observed lying in bed. R4 was unable to demonstrate the ability to turn side to side in bed. On 01/09/24 in the morning, a Caregiver indicated staff turned R4 on their side periodically throughout the day, because R4 could not do it on their own. Review of R4's medical record did not reveal a documented bedfast waiver. On 01/09/24 in the morning, the Administrator confirmed R4 did not have a bedfast waiver. Severity: 2 Scope: 1</p>	0620	<p>Administrator has applied for bedfast waiver for resident and is in progress. Administrator will be in charge of making sure bedfast waiver applications are completed. Administrator will assess need for bedfast waiver on admission, during 6mo care reviews and when staff reports a change in mobility. Staff had short meeting to address the need for updated information regarding residents that are bedfast or stay in bed for larger portions of time.</p>		01/25/2024

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1830 SS= D	<p>Infection Control Required Training</p> <p>Inspector Comments: Based on record review and interview, the facility failed to ensure the secondary infection control designee had completed 15 hours of infection control training (Employee #4). Findings include: Employee #4 (E4) E4 was hired on 10/01/22 as a Caregiver. Review of E4's record lacked documented evidence of 15 hours of training concerning the control and prevention of infections from an approved organization. On 01/09/24 in the morning, the Administrator confirmed E4 was the secondary infection control program designee. The Administrator was unable to provide documented evidence the required infection control and prevention training had been completed for E4.</p> <p>Severity: 2 Scope: 1</p>	1830	<p>Administrator will ensure that an additional (2nd) member of staff will have Infection control training from CDC 15 hours. Caregiver identified has taken the course and received an attached certificate. Administrator will maintain a tickler file to ensure that a minimum of 2 identified staff members have certification. Tickler shall be reviewed along with other data for expirations monthly.</p>		01/25/2024