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 _____	**02/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELBROOK GRAND MONTECITO LLC	**6660 GRAND MONTECITO PARKWAY, LAS VEGAS, NEVADA ,89149**

(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 survey conducted at your facility on 01/27/22 and 02202/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 46 Residential Facility for Group beds for Elderly or Disabled Persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was forty. The sample size was seven. The facility received a grade of A. One complaint was investigated. Complaint #NV00065463 with seven allegations was substantiated without deficiency. Allegation #1. Two residents resident with dementia were found naked in a room together was substantiated without deficiency based on review of facility incident reports which documented the incident on 11/22/21, review of policies "Providing for Sexual Expression" and "Behavior Policy" and interviews with a Medication Technician, a Resident Care Coordinator and the Executive Director who indicated two residents were found naked together on a bed but were not touching each other and were redirected apart from each other by staff per the facility policy. Allegation #2. The facility failed to provide adequate supervision was unsubstantiated based on observation of staff, review of staffing schedules from October 2021 to January 2022 which show proper staff/resident ratio and interviews with two Caregivers, a Medication Technician and the Executive Director who indicated they do not have staffing concerns and use staffing agencies when extra staffing was needed. Review of Caregiver Responsibility policy which documented rounds will be made every hour during the day and every two hours at night. Interviews with two Caregivers, a Medication Technician and the Executive Director who indicated rounds are made	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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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	every 30 minutes to one hour and documented in the health records when requested by the physician or family members. Allegation #3. Residents are not provided activities was unsubstantiated based on observation of activities currently taking place, review of activity calendar and interviews with two Caregivers, a Medication Technician, the Activities Director, three residents and the Executive Director who indicated activities take place every two hours throughout the day. Allegation #4. A residents belongings were found in a laundry basket in the shower, under running water was unsubstantiated based on review of incident reports which did not document this event, and interviews with a Medication Technician, the Executive Director and a Resident Care Coordinator who indicated they do not recall this incident taking place and residents linens were removed by family when resident was discharged. Allegation #5. A resident attempting to stand was pushed back into the chair by a staff member was unsubstantiated based on review of incident reports which did not document this event, and interviews with a Medication Technician, the Executive Director, and a Resident Care Coordinator who indicated they did not see this happen and the staff member would have immediately been terminated and police notified if the incident was observed. Allegation #6. A discharged resident's personal property went missing and was not returned by the facility was unsubstantiated based on incident reports which did not document any instances of the resident's items missing, and interviews with a Medication Technician and the Executive Director who indicated the resident was discharged with all belongings and the family did not report any items missing. Allegation #7. Residents in the dining room are not served food or drinks was unsubstantiated based on observation of lunch meal with all residents having a meal and drink in front of them, review of			

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	incident reports which did not document any issues related to food or drink service and interviews with a Medication Technician, two Caregivers and the Executive Director who indicated they were unaware of any issues with residents not being fed or given a drink when requested. The investigation into the allegations included: Observation of staff to resident ratio, staff making rounds in Memory Care, resident to staff interactions, residents in dining area during meal service, resident to resident interactions and activities taking place. Interviews with two Caregivers, a Medication Technician, a Resident Care Coordinator, the Activities Director, three residents and the Executive Director. Review of facility incident reports, grievance reports, staffing schedules, activity calendar, policies on "Providing for Sexual Expression," "Caregiver Responsibilities" and "Behavior Policy." Medical records including care plans, physical exams, activities of daily living assessments and admission documents for seven residents including the resident of concern. 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. No regulatory deficiencies identified.			