Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9545	A. BUILDING _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA PARADISE CARE, LLC	1809 WESTWIND ROAD, LAS VEGAS, NEVADA ,89146

(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 survey and bed increase completed at your facility on 02/20/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The facility has applied and was approved for a two bed increase for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents for a total of 10 beds. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of A. 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		
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on interview and record review, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/31/24, with diagnoses including diabetes and hypertension. R1's	0515	1. Administrator and owner immediately developed a person-centered service plan for all residents. 2. A person-centered service plan will be developed for each resident upon admission. 3. Administrator will regularly check resident files for compliance and completion. 4. The administrator will make sure that POC is implemented. 5. Completed on January 18, 2025. 6. Please see attached copies of person-centered plans.	01/18/2025

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	file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 11/06/23 with diagnoses including senile degeneration of the brain. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on 07/15/20, with diagnoses including Alzheimer's disease and hypertension. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 08/23/21, with diagnoses including senile degeneration of the brain. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 10/21/24, with diagnoses including diabetes and hypertension. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 10/01/24, with diagnoses including dementia and hypothyroidism. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 12/22/23, with diagnoses including Parkinson's disease and arthritis. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted to the facility on 08/05/24, with a diagnoses including dementia. R8's file lacked a person-centered service plan. On 01/15/25 in the afternoon, the House Manager acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7, and R8. Severity: 2 Scope: 3			
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate	1600	1. Administrator immediately developed a gender identity form that shows pronoun and gender preference of all residents. 2. A gender identity form will be done for each resident upon admission. 3. Administrator will regularly check resident files for compliance and completion. 4. The administrator will make sure that POC is implemented. 5. Completed on feb. 08, 2025. 6. Please see attached copies of gender identity forms.	02/08/2025

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	information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on interview and record review, the facility failed to ensure 8 of 8 residents files included documentation of preferred pronoun, gender expression and sexual orientation. Findings include: Review of 8 of 8 resident files revealed the facility did not document, residents preferred pronoun, gender expression and sexual orientation. On 01/15/25 in the morning, the House Manager confirmed they did not ask and document 8 of 8 residents preferred pronoun, gender expression and sexual orientation and had not added this information to their admission documents. Severity: 1 Scope: 3			