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 _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT NIGHTINGALES	**813 FAIRWAY DRIVE, LAS VEGAS, NEVADA ,89107**

(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 01/11/23 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Groups beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, Category II residents. The census at the time of the survey was nine. The sample size was six. The facility received a grade of A. One complaint was investigated. Complaint #NV00067492 with four allegations was substantiated. Allegation #1: A resident had burns from a hot shower was substantiated (see Tag Y0174). Allegation #2. Family was not notified of a change in condition of a resident was substantiated (see Tag Y0850). The investigation into allegations included: Observations of the residents' arms, heads, and faces, hot water temperature, lunch meal service, linen supply and caregivers and owner interactions with the residents. Interviews with the owner, two caregivers, a Registered Nurse, four residents and a primary care physician. Record review of five current resident's and one discharged resident, including the resident of concerns, physical exams, activities of daily living, medication administration record, hospital records and incident reports for the previous 12 months. Document review including current menu, resident sign in and out log, facility incident reports and admission procedures. 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 investigation, 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:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ANNE ESPINUEVA Title: MANAGING MEMBER Date: 03/08/2023

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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0174 SS= G	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure water was at a safe temperature to prevent 1 of 6 residents (Resident #6) from being burned. Findings include: Resident #6 (R6) was admitted on 09/01/20 with diagnosis of schizophrenia and hypertension. The resident was discharged on 11/14/22. An incident report dated 11/11/22 documented R6 suffered a first degree burn to the face and scalp from hot water in the shower. Physician's note dated 11/11/22 documented R6 had a burn wound to left side of face, upper back and small area of lumbar spine. R6 was prescribed Silvadene cream to be applied to the burn sites for pain control and healing. Emergency room note dated 11/14/23 documented R6 presented with a second degree burn to the side of the face with pain. A physical exam documented R6 had a partial thickness second degree burn to the left side of the face with redness of the skin. R6 was referred to the burn unit for further evaluation. A Burn Care unit admission note dated 11/14/23, documented R6 had a scald burn to the left side of the face due to the presence of a scald. On 01/11/23 in the morning, a resident indicated R6 came running out of the bathroom on 11/11/22 screaming in pain and yelling that R6 burned R6's face with hot water. On 01/11/23 at 10:30 AM, a physician indicated R6 suffered first or second degree burns to R6's face after getting into a shower with water that was too hot. On 01/11/23 in the	0174	Water heater temperature was adjusted by plumber to meet regulation requirement of 100 to 110 degrees Fahrenheit and a thermostat was installed attached to the shower head to monitor accuracy of water temperature (see attached photo). Residents in the home were educated on new installed shower thermostat and that to report any discrepancies that do not follow the informed guidelines. New admissions will also be informed of the same procedures. Caregiver to check water temperature daily to ensure safety. This changes has already been in place since 03/06/2023.	03/06/2023

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	morning, a temperature check was conducted of hot water temperatures in a shower in Bathroom #1 and Bathroom #2 and registered at 121 degrees Fahrenheit in Bathroom #1 and 125 degrees Fahrenheit Bathroom #2. On 01/11/23 in the morning, a Caregiver acknowledged the hot water temperatures registered at 121 degrees Fahrenheit in Bathroom #1 and 125 degrees Fahrenheit in Bathroom #2. On 01/11/23 in the morning, the Owner confirmed R6 acquired the burns to the face and scalp from taking a shower with water that was too hot and acknowledged the water temperatures in Bathroom #1 and Bathroom #2 were too hot and could have caused a burn. Severity: 3 Scope: 1 Complaint #NV00067492			

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0850 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on interview and document review, the facility failed to ensure the family of a resident, who sustained a burn injury, was notified for 1 of 6 residents (Resident #6). An incident report dated 11/11/22, documented Resident #6 (R6) sustained a burn injury to the face and scalp. The incident report lacked documented evidence the family of R6 was notified. On 01/11/23 the owner confirmed the facility did not notify the family of R6 because they were unaware they were required to do so. Severity: 2 Scope: 1 Complaint #NV00067492	0850	To comply with the regulation NAC 449.274, the facility will notify family member/s or legal guardian of resident of illness, injury or accident; If a resident in the facility becomes ill or is injured, the resident's physician and a member of the resident's family will be notified at the onset of illness or at the time of the injury. The facility will make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and request emergency services when such services are necessary. The Administrator will be in charge of notification.	03/08/2023