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
	9966	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST SOLUTIONS HOME CARE	**7245 SCOTTSMOOR CT, LAS VEGAS, NEVADA ,89156**

(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 State Licensure annual survey completed at your facility on 01/04/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for four Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and/or persons with chronic illness, Category II residents. The census at the time of survey was four. Four resident files and three 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 investigation, 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		

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 REPRESENTATIVE'S SIGNATURE Name: MARIA T N ACOBA Title: Administrator Date: 01/14/2024

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0930 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation and interview, the facility failed to ensure resident records were properly stored in a locked cabinet. Findings include: On 01/04/24 at 9:30 AM, a file cabinet which contained resident files was found unlocked. On 01/04/24 in the morning, the Owner acknowledged the file cabinet with resident files in it was unlocked and should be kept locked up at all times. Severity: 2 Scope: 3	0930	1) Right after the survey on 1/04/2024; Administrator called for a meeting and reminded all employees to always lock the cabinet containing residents files as each records are considered confidential documents. A copy of a photograph hereinto attached and marked as Exhibit"A" TAGY0930 photo of the locked cabinet. 2) Administrator should randomly check the file cabinets and make sure they are locked. 3) Administrator should monitor for compliance. 4) Person responsible : Administrator 5) Completion date: 1/12/2024	01/12/2024

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1815 SS= C	Emergency Preparedness Plan Inspector Comments: Based on interview and document review, the facility failed to ensure an Emergency Preparedness Plan was created and available onsite. Findings include: Review of facility policies and procedures revealed the facility did not have an Emergency Preparedness Plan. On 01/04/24 in the morning, the Owner confirmed they did not have documentation on what the facility would do in the event of an Emergency. Severity: 1 Scope: 3	1815	1) An emergency preparedness plan is here to attached and marked as exhibit "B" TAG Y1815; exhibit "B-1" TAG Y1815; exhibit "B-2" TAG Y1815 and exhibit "B-3" TAG Y1815 and exhibit "B-4" TAG Y1815 respectively. 2) Administrator should be aware of this requirement and all the group homes that she handles should have this written Emergency Preparedness Plan and all employees are trained so that in case of any emergencies they know what to do. A copy of all emergency Phone numbers should always be visible close to the house phone where everybody can see. 3) Administrator should monitor for compliance. 4) Person responsible: Administrator. 5) Completion date: 01/14/24	01/14/2024