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 _____	**08/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CARE HOME LLC	**1012 PARADISE VIEW ST., HENDERSON, NEVADA ,89052**

(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, complaint, and infection control State Licensure survey conducted at your facility on 08/17/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, persons with Alzheimer's Disease, and/or persons with chronic illness, Category II residents. The census at the time of the survey was nine. Nine resident files and five employee files were reviewed. The facility received a grade of A. One complaint was investigated. Complaint #NV00066785 with two allegations was unsubstantiated. Allegation #1 - A resident was abused by a facility staff member was unsubstantiated based on observations of residents who were free of bruising with no signs of abuse. A facility incident report dated 04/21/22 documented there were no witnesses to the allegation of abuse to a resident. The resident of concern was discharged on 04/30/22, and could not be interviewed. Interviews with staff and residents revealed there were no witnesses to the allegations of abuse and residents reported no issues with abuse from staff at the facility. Allegation #2 - The facility failed to report an allegation of abuse to Aging and Disability Services Division (ADSD) was unsubstantiated based on an interview with the Administrator who indicated not being aware of the allegation of abuse until a representative from ADSD arrived at the facility on 04/20/22, to conduct an investigation. The Administrator reported ADSD was already aware of the allegation of abuse. The facility incident report dated 04/21/22 documented the facility conducted an investigation into the reported allegation of abuse after ADSD reported the allegation to the facility. Investigation into the allegations included: Observation of staff	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: CHRISTOPHER LANE | Title: Administrator | Date: 09/21/2022

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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	and resident interactions. Interviews with two Caregivers, the Administrator, and a Resident. Record review of incident reports and employee and resident files. 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 deficiencies were identified:			

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0335 SS= F	Bedroom - Certain areas as bedroom prohibited - NAC 449.221 Use of certain areas in facility as bedroom prohibited. (NRS 449.0302) A hall, stairway, unfinished attic, garage, storage area or shed or other similar area of a residential facility must not be used as a bedroom. Any other room must not be used as a bedroom if it: 1. Can only be reached by passing through a bedroom occupied by another resident; or 2. Is used for any other purpose. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident's bathroom closet was not being used as a bedroom for 1 of 2 caregivers who slept at the facility. Findings include: On 08/17/22 at 2:00 PM, the bathroom closet located in Resident #3's (R3) bedroom was being utilized as a bedroom for a caregiver. The caregiver would have to pass through R3's bedroom to gain access into the bathroom closet. In R3's bathroom closet there was a bed, a nightstand and personal items, including clothing, food, and prescription medications which belonged to the caregiver. An interview with Employee #3 (E3) revealed the bed, personal items, and medications belonged to them. On 08/17/22, the Administrator acknowledged the use of a bathroom closet as a caregiver's bedroom was inappropriate and a designated caregiver room in the facility was available for the caregiver to reside in. Severity: 2 Scope: 2	0335	**1)** We have corrected the specific finding by removing the fold-out bed & other bedroom items from the closet. Caregiver #2 did not mention this to management that this area was used when the employee bedroom that was assigned became too hot this summer **(see attached photo of cleared area)**. **2)** The employee responsible has reviewed the NRS 449.0302 and NAC guideline for this statute and understands this cannot happen again. To help prevent further summer high heat problems, a cooler will be available in the employee room for added comfort. **3)** Both the Manager and the Administrator will inspect the closet areas more frequently during early morning and evening times so this will not happen in the future. **4)** The Manager will be responsible for monitoring this corrective measure. **5)** August 19, 2022	08/19/2022

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0995 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure an exterior gate in the backyard was locked. Findings include: On 08/17/22 at 1:30 PM, the backyard gate that led to the street was not secured. The Administrator acknowledged the gate was not secured. The Administrator indicated the gate should have been locked. Severity: 2 Scope: 3	0995	**1)** We have discussed with the caregivers their responsibility to make sure the back gate is locked when the gardeners finish with their work, and especially each week when the refuse is taken out front for pick-up. 2) Management and the Administrator will do a better job in viewing this area on each visit to the facility. All areas requiring locks including the laundry area, kitchen area (utensils & sharp objects), all bathroom cabinets with magnetic locks and garage storage areas will be checked. This will now be done on a daily basis instead of a previously random basis (**see attached checklist item**). 3) We have added a checklist item on this deficiency to the daily cleaning log to better remind staff and monitor the corrective measure. 4) The Manager will be responsible for overall implementation of this corrective action. 5) 09/01/2022	09/01/2022

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0999 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents with diagnoses of Alzheimer's disease and/or dementia. Findings include: On 08/17/22 at 1:00 PM, a bathroom cabinet was unlocked and contained one bottle of tub and tile cleaner, window cleaner, and powder cleanser. The center cabinet located under the sink had an inoperable lock, the cabinet contained several bottles of shampoo, lotions, and various other personal hygiene items. Three bathrooms located throughout the facility, had a magnetic key to unlock cabinets under the sinks. The magnetic key was kept in an unlocked medicine cabinet in the bathrooms. Shampoo, lotion, and mouthwash were being stored unsecured under the sink vanity area. The Administrator acknowledged that all cabinets containing toxic substances should have been locked at all times. Severity: 2 Scope: 3	0999	**1)** All caregivers have been made aware of the dangers in allowing access to toxic substances, even a momentarily error in judgement can be enough for harm to occur, **(see attached acknowledgement they will follow protocols in the future).** **2)** As stated previously, Management and the Administrator have added another checklist item to the cleaning log where verification will be made that locked areas are indeed locked on a daily basis. 3) The added checklist item to the daily cleaning log will monitor this corrective action. Management &/or Administrator's daily checks will verify as well (**see previous attached Cleaning Log**). 4) The Manager will be responsible for overall implementation of this corrective action. 5) 09/01/2022	09/01/2022