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
	10013	A. BUILDING _____ B. WING _____	08/22/2023

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 08/22/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease and/or Chronic Illness, Category II residents. The census at the time of the survey was eight. Ten 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 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		

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure a background check was completed under the facility's Nevada Automated Background Check System (NABS) account for 1 of 5 employees (Employee #1) Findings include: Employee #1 (E1) E1 was hired on 10/04/22 as the Administrator. E1's file lacked documented evidence of a completed background check under the facility's NABS account and no documented evidence in NABS of fingerprints or background checks performed within 6 months of E1's hire. On 08/22/23 in the afternoon, the Administrator was unable to provide a completed background check under the facility's NABS account and verbalized to not knowing that all new hires needed a background check when hired by the facility. Severity: 2 Scope: 1	0104	1) E1 submitted the application through NABS right away and got fingerprinted (See attachment A). We will keep track of all employee's background check status regularly to ensure the facility is compliant with the regulation. 2) In the future the facility will ensure a background check for all employees to be completed within 10 days of hire. 3) The manager and the administrator will review NABS more strictly every 30 days. 4) The manager and the administrator will be responsible for monitoring this corrective action. 5) Date 09/05/23	09/11/2023

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0730 SS= D	Manual Removal of Fecal Impactions - NAC 449.2718 Residents requiring manual removal of fecal impactions or use of enemas or suppositories. (NRS 449.0302) 1. A person who requires the manual removal of fecal impactions or the use of enemas or suppositories must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is able to provide the care for himself or herself; or (b) The care is administered according to the written instructions of a physician by a medical professional who has been trained to provide that care. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident was administered suppositories by a medical professional for 1 of 8 residents (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 08/18/23 with diagnoses including left leg amputation, cardiovascular accident, diabetes, hypertension, and acute kidney failure. R5's August 2023 Medication Administration Record (MAR) revealed two facility Caregivers (Employee #3 (E3) and Employee #4 (E4)) administered suppositories to R5 on 08/18/23 through 08/22/23. On 08/22/23 in the morning, E4 acknowledged they administered suppositories to R5 on 08/19/23 through 08/22/23, and did not know the administration required a medical professional such as a home health nurse. On 08/22/23 in the morning a Home Health nurse was at the facility and verbalized to knowing the caregivers of the facility were not to administer suppositories to residents and could not explain why the caregivers were administering the suppositories. On 08/22/23, the House Manager acknowledged E3 and E4 administered suppositories to R5, and explained suppositories should be administered by a medical professional not the facilities caregivers. Severity: 2 Scope: 1	0730	1) R5 was admitted to the facility on 08/18/23 which was a Friday and R5 did not have any medical professional available to administer her suppository until the following week. This specific deficiency has been corrected by educating and ensuring that employees at the facility are not allowed to administer suppositories and it should only be administered by a medical professional such as a home health SN. When R5's home health SN visited R5, we explained that they are the ones to administer suppositories and they agreed. 2) The facility will implement a log to keep track and also to make sure that the care is administered according to the written instructions of a physician by a medical professional who has been trained to provide care. (See attachment B). 3) The suppository administration log will be placed in the MAR to make sure they are recorded every time by the medical professional. 4) The administrator and the manager will be responsible for monitoring the corrective action. 5) 09/09/23	09/11/2023
0936	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS	0936	1) We've been contacting R1's PCP and the lab for the Quantiferon report for several times since it was done on R1 but we never received the report. So we contacted R1's	09/11/2023

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	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure residents' Tuberculosis (TB) screenings were followed up on after unclear TB results were obtained for 2 of 8 residents (Residents #1 and #2). Findings include: Resident #1 (R1): R1 was admitted on 01/17/23 with diagnoses including allergic rhinitis, alteration in mobility due to weakness, and asthma. R1's resident file lacked documented evidence of the result of a Quantiferon Gold TB test performed on R1 on 01/20/23. On 08/22/23 in the afternoon, the House Manager reported the performing laboratory could not provide the results of R1's Quantiferon Gold TB test. The House Manager verbalized the facility should have followed up on the inconclusive result. Resident #2 (R2): R2 was admitted on 11/15/22 with congestive heart failure and dyspnea. R2's resident file documented a Quantiferon Gold TB test dated 11/13/22 with a result of Indeterminate. R2's file documented multiple chest X rays and computerized tomography (CT) scans which were not performed to rule out TB. R2's file lacked documented evidence the facility had a chest X ray to rule out TB and the facility did not follow up on the Indeterminate TB result. On 08/22/23 in the afternoon, the Administrator acknowledged R2 did not have a TB screening with a negative or positive result for TB and a chest X ray to rule out active TB. The Administrator confirmed the facility did not follow up on R1's TB screening and chest X rays to determine what the acutal result was of the TB screening. Severity: 2 Scope: 2		Home Health agency to see if they could help but didn't hear from them regarding the report either. The lab company stated the report was pending, so we waited until it was final but they never sent us the final report. So we requested for a new Quantiferon test to be done and the lab tech came the next day for it and we received the report (See Attachment C). R2 had the Quantiferon test done on 11/13/22. A few days later R2's hospice agency conducted a chest X-ray on him. We received R2's Quantiferon report shortly after and it stated it was indeterminate. But we also had R2's chest X-ray report and it did not state there was an evidence of active TB so we used that report for chest X-ray. But the purpose of the chest X-ray wasn't to rule out TB specifically so we asked the healthcare provider to conduct a new 2 step TB test for R2 and we received the report (See Attachment D). 2) We will make sure to obtain the TB test reports at the time of completion and it ever the report is indeterminate, we will order chest X-ray specifically to rule out TB. 3) The administrator and the manger will review resident's folders more strictly every 30 days to make sure all requirements are met. 4) The administrator and the manager will be responsible for monitoring this corrective action. 5) 09/09/23	

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0991 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: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an exit door was alarmed as evidenced by: On 08/22/23 at 10:43 AM, the alarm was not operating on the door leading to the garage from the laundry room. On 08/22/23 at 10:45 AM, the House Manager acknowledged the alarm was not working and was unaware the door leading to the garage from the locked laundry room needed to be alarmed. Severity: 2 Scope: 3	0991	1) The laundry room has a lock and only the employees of the facility has access to the key. The door to the garage has a lock as well. We were not aware that the door leading to the garage from the laundry room needed an alarm since the laundry door is locked at all times. But as it is required by regulation, we fixed the alarm by changing the battery to make sure it is in a working condition (See Attachment E). 2) We will make sure all of the facility's alarms operate, as required by regulation. 3) The administrator and the manger will check on all the alarms every 30 days to make sure they are in a working condition. 4) The administrator and the manager will be responsible for monitoring this corrective action. 5) 09/09/23)	09/11/2023