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 _____	**11/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANIKEHA RESIDENTIAL	**465 EAST ROBINDALE ROAD, LAS VEGAS, NEVADA ,89123**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 11/05/24 and completed on 11/18/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was five. The sample size was five. The facility received a grade of A. There was one complaint investigated: Substantiated: 1. Complaint #NV00072291 was substantiated. (See TAGS Y088, Y501 and Y515) The investigation of the Complaint included: Observation of resident transfers, residents receiving care and assistance, facility incontinence supplies, home health access to residents and tour of the facility. Interviews were conducted with residents, the House Manager, a Hospice Home Health Aide, the Resident Care Coordinator, and the Administrator's Designee. Clinical Record Review of 5 records, which included the resident of concern. Six employee files were reviewed. Document review included facility policy and procedures, employee schedules, and admission documents. 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		
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after	0088	1. We will correct this finding by training staff on schedule policy. The schedule policy update was sent via GroupMe for reading and understanding new policy. Scheduling will be posted monthly in the facility and retained for 6 months in a binder on property. Any edits or call offs	12/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NICHOLE SCHMAL Title: Executive Director Date: 12/03/2024

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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	the schedule expires. Inspector Comments: Based on document review and interview, the facility failed to maintain an accurate staffing schedule, including the names of the caregivers and medication technicians scheduled to work and staffing changes. Findings include: On 11/05/24 in the afternoon, review of the September 2024 and October 2024 Staffing Schedule revealed routine shifts lacked the names of the caregivers or medication technicians that were scheduled to work. There were no amendments to the schedule that indicated the employees that worked those shifts. The September 2024 employee schedule documented the 6:30 PM shift to 6:30 AM shift was left blank with no documented employee name for the month of September 2024. The 6:00 AM to 6:00 PM shift was left blank with no documented employee name every Monday, Tuesday, and for the month of September. The 12:00 PM to 6:00 PM shift was left blank with no documented employee name every Thursday for the month of September. The October 2024 employee schedule documented the 6:30 PM shift to 6:30 AM shift was left blank with no documented employee name from October 1, 2024, until October 12, 2024. Then left blank with no documented employee name October 18, 2024, October 19, 2024, and October 25, 2024, through October 30, 2024. The 6:00 AM to 6:00 PM shift was left blank with no documented employee name October 1, 2024, to October 3, 2024, from October 7, 2024, to October 10, 2024, from October 21, 2024, to October 24, 2024 and October 28, 2024 to October 30, 2024. The 10:00 PM to 6:00 AM shift was left blank with no documented employee name on October 13, 2024, October 17, 2024, October 20, 2024, October 24, 2024. The 6:00 PM to 6:00 AM shift was left blank with no documented employee name on October 31, 2024. On 11/07/24 at 11:55 AM, the Executive		or changes to the schedule will reflect on that schedule in pen. 2. This training will be conducted on December 3, 2024 on policy for staff schedule. 3. This will be monitored monthly for filing and daily for changes or edit. 4. The Manager will monitor changes and call outs to correct the schedule when these instances occur. 5. December 8th at 1pm this training will be conducted. 6. Policy notice of change given to all staff and picture of GroupMe sent to employees. 7. We will do this for the menus, schedules and activities so this deficient practice does not recur.	

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	Director acknowledged employee names were not on the schedule provided as the facility used agency staff to fill shifts as well as permanent staff. Severity: 1 Scope: 3 Complaint# NV00072291			
0501 SS= C	Written Policies - Visiting hours - NAC 449.258 Written policies for facility; policy on visiting hours; residents ' mail; compliance with policies. (NRS 449.0302) 2. A policy on visiting hours must be established to promote contact by the residents with persons who are not residents of the facility. The policy regarding visits must be flexible to ensure that every resident has the opportunity to retain and strengthen ties with family and friends. Inspector Comments: Based on observation, interview and document review, the facility failed to follow its own resident visitation policy allowing agencies to visit residents without prior notice. Findings include: On 11/05/24 in the morning, a sign was posted on the front security gate which documented that no outside agency was to come in the house without being scheduled. On 11/7/24 in the morning, the Executive Director verbalized the sign was new and being unaware of why the sign was posted. On 11/15/24 in the morning, the Executive Director verbalized the sign was not to limit resident visitors, but rather to limit outside vendors. Facility Policy (no date) documented staff shall observe and respect the privacy of all residents residing in the community. The procedure was to (8) have their visitors, including ombudsman and advocacy representatives permitted to visit privately during reasonable hours and without prior notice, provided that the rights of other residents were not infringed upon. Severity: 1 Scope: 3 Complaint# NV00072291	0501	1. We will correct this specific finding by posting facility policies for visiting hours. Which was signed by all residents and/or POA/Guardians. Visiting Hours: From 9 a.m. until 7:00 p.m. daily.Accommodations can be made by calling the manager for other visiting times. 2. This will be posted on the facility wall to ensure that all staff and residents family is aware of the policy. 3. This corrective action will be monitored monthly to ensure the post has not come down. 4. The Manager will ensure that all persons are aware of this policy and they can contact them for any further information. 5. December 3, 2024 6. Copy of the the document posted. 7. All other polices are posted as well to ensure that all friends and family are aware of all the policies.	12/03/2024
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall	0515	1. We will correct this finding by creating GroupMe chat and conducting a care plan updating training for all staff to review before assisting any resident. Tab 5 in their	12/03/2024

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	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 record review and interview, the facility failed to follow a person-centered service plan for 1 of 5 residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 01/14/24 with a diagnosis of metabolic encephalopathy. R1's Face Sheet documented R1 was a two person assist as of May 2024. On 11/05/24 in the morning, Employee #1 (E1) verbalized the process for transferring a resident who was a two-person assist was for one caregiver to get on one side of the resident and the other caregiver to get on the other side of the resident, hold the resident's pants and then safely transfer them. The Facility documented on 07/09/24 at 11:59 AM R1 was observed in the dining room with a skin tear on their left arm. The skin tear was medium size that a small gauze could cover. Hospice was notified of the skin tear. E1 had picked R1 up out of the recliner to put them in the wheelchair to go to the dining room without the assistance of another caregiver resulting in a skin tear. Hospice notes documented on 07/11/24 at 9:27 AM hospice spoke to a Hospice Nurse about the skin tears to the arm that E1 had told the Hospice Nurse about. The Hospice Nurse reported asking a Certified Nursing Assistant (CNA) from the hospice agency about the skin tears and if they had seen them. The CNA let the Hospice Nurse know they were caused by a one person transfer of R1 by the group home staff. The CNA had offered to assist with the transfer but were denied. In an emailed dated 11/05/24		binder states how we will care for these individuals and what activities they are capable of performing. Staff will be also trained on updating care plan or capabilities of the residents via GroupMe our secure chat. 2. The care plan training will be done upon entering facility on first day of hire, the staff will be added to the chat and any changes to care plan will be reported on GroupMe to all staff. All staff will acknowledge and confirm understanding of the new care plan and this will be documented in this chat. 3. This will be monitored daily 4. by the Administrator, Owner and Manager along with all the staff. 5. This was completed December 3, 2024 6. Picture of the GroupMe with all the Staff 7. This will ensure any and all updates on residents and policies are distributed to all staff and they will confirm information was received so we can care for these residents in the best manner.	

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	the Executive Director documented R1's Care Plan was updated in May of 2024 to include two person transfers. On 11/15/24 in the morning, the Executive Director verbalized R1 was changed to a two person in May of 2024. Severity: 2 Scope: 1 Complaint# NV00072291			