| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 10333 | A. BUILDING _____ B. WING _____ | 01/24/2023 |

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| AEGIS LIVING LAS VEGAS | 9100 WEST DESERT INN RD., LAS VEGAS, NEVADA ,89117 |

| (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 |
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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of the Annual State Licensure and Infection Control survey conducted at your facility on 01/24/23, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility is licensed for 72 Residential Facility for Group beds for elderly or disabled persons and/or persons with Alzheimer's disease and Assisted Living services, Category II residents. The census at the beginning of the survey was 49. 15 resident records and six employee records were reviewed. The facility received a grade of C. 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 | | |
| 0255 SS= E | Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division.<br><br>Inspector Comments: Based on observation on 01/24/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the main kitchen, the low temperature dish machine did not reach the minimum 120 degrees Fahrenheit (F) during the final rinse cycle and there was no detectable level of chlorine sanitizer dispensed. 2. Major Violations: a. In all neighborhood kitchens, the cabinets around the sinks and dish machines were warped and in disrepair. b. In the main kitchen, the paper towel dispenser at the hand washing sink was not operating and there were no paper towels readily available. c. The floor throughout the | 0255 | •□□□□□□□□At the current time the community has purchaseda dedicated 47-gallon hot water tank for the main kitchen dish machine. Supportingdocuments for the purchase have been uploaded and install date was 2/17/2023.<br><br>•□□□□□□□□Ecolab was able to visit the community on1.24.2023 to service the main kitchen dish machine. There was a failure of the squeezetubes that prevented chemical sanitizer from running thru the machine at thetime of State Survey. This was resolved during Ecolab's visit on 1.24.2023.Please see supporting documentation uploaded and reference parts replaced forMain Kitchen ES-Ecolab-2000.<br><br>•□□□□□□□□Main Kitchen Dish Machine daily log has beencreated to ensure we are checking sanitizer coming thru the machine. This willbe maintained in the kitchen area and will allow for communication should therebe any | 02/17/2023 |

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| | kitchen was pitted, deteriorating and accumulating dirt. Severity: 2 Scope: 2 | | issue with sanitizer in the future. GM will review weekly and sign offon log. Training will be provided on 3/8/23 & 3/9/23 and to all theculinary staff on the process.<br><br>•□□□□□□□□Neighborhood Kitchens are being addressed at thecurrent time. Neighborhood B is currently under renovation and should becompleted by end of April. Upon completion of Neighborhood B, Neighborhood Awill be started. Upon completion of Neighborhood A, Neighborhood C will bestarted. All Neighborhood Kitchens should be completed by the end of 2023. Designand further specifications have been uploaded under documents. This renovation includesnew countertops, and new cabinetry. Aspart of this renovation, a comprehensive plan has been developed to ensureresidents disruption of services is minimized. Careful thought has been given to the alternate dining and activityaccommodations while the kitchen areas are being renovated.<br><br>•□□□□□□□□Culinary Service Director to complete 2trainings with all Culinary Team Members. These will be on Cleaning andSanitizing and Hand Hygiene. See training documentation in uploaded documents.Training will be conducted by 3/10/2023 and attendance sheet will be availableupon completion.<br><br>•□□□□□□□□New cleaning techniques for Kitchen floor arecurrently being executed per vendor specification. The floor installer suggested using SimpleGreen with a 1:1 solution and let stand for a few minutes to release thelong-term dirt that has settled in the texture of the floor. This process will be repeated untilsatisfactory results are achieved. | |

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| 0870 SS= E | Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).<br><br>Inspector Comments: Based on record review and interview, the Administrator failed to ensure a medication review was completed at least once every six months for 5 of 15 sampled residents (Residents #1, #2, #3, #4, and #5). Findings include: Resident #1 (R1) R1 was admitted to the facility on 7/1/22 with diagnoses including Alzheimer's disease and Gastroesophageal reflux disease (GERD). R1's file lacked documented evidence of a six-month medication review. Resident #2 (R2) R2 was admitted to the facility on 6/2/22 with diagnoses including dementia and hypertension. R2's file lacked documented evidence of a six-month medication review. Resident #3 (R3) R3 was admitted to the facility on 6/8/22 with diagnoses including Parkinson's disease and major depression. R3's file lacked documented evidence of a six-month medication review. Resident #4 (R4) R4 was admitted to the facility on 4/16/22 with diagnoses including Senile Degradation of the Brain and GERD. R4's file lacked documented evidence of a six- | 0870 | •□□□□□□□□Entire community medication reviews were completed by Omnicare registered Pharmacist on 1.29.2023. These are currently being distributed to PCP's and the community has obtained 65% back from PCP. We estimate a 100% compliance by 3/10/2023 or sooner.<br><br>•□□□□□□□□Of the 5 residents that were found deficient, 4 med reviews are completed and supporting documentation has been uploaded. We estimate a 100% compliance by 3/10/2023 or sooner<br><br>•□□□□□□□□The preferred Pharmacy partner, Omnicare will complete a quarterly review for all residents in the community. Next visit is scheduled on April 2023. Please see supporting email.<br><br>•□□□□□□□□Administrator completed review NAC 449.2742 with Health Services Director as well as re-education of Aegis's internal policy for Documentation Standards for Medication. Please refer to NAC sign off uploaded in documents. | 02/17/2023 |

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| | month medication review. Resident #5 (R5) R5 was admitted to the facility on 6/8/19 with diagnoses including Unspecified Dementia and acute myocardial infarction. R5's file contained a last medication review dated 2/1/22, however, the resident's file lacked documented evidence of a six-month medication review since 2/1/22. On 1/24/23 at 12:06 PM, the Health Services Director confirmed the medication reviews were not completed every six months, per the requirement. Severity: 2 Scope: 2 | | | |
| 0878 SS= D | Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist | 0878 | •□□□□□□□□Re-education complete for Health Services Director detailing the appropriate medication approval processes, specifically defining the three requirements in order to approve; correct supply, corresponding Dr.'s orders and accuracy of EMAR.<br><br>•□□□□□□□□Health Services Director will complete a daily audit of the central log to maintain accuracy of the outside supply that is brought in by family members. This audit will include a physical check of what is on the cart.<br><br>•□□□□□□□□In Service training for all Medication Care Managers will be completed by 3/10/23 and sign in sheets will be uploaded afterwards. Aegis's internal policy for Documentation Standards for Medication will be reviewed. Emphasis with Medication Care Team on the 5 rights for passing meds. Right resident, right medication, right dose, right route, right time will be made. See uploaded policies. | 02/17/2023 |

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| | must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.<br><br>Inspector Comments: Based on observation, interview and record review, the facility failed to administer medication as prescribed for 1 of 15 sampled residents (Resident #15). Findings include: Resident #15 (R15) R15 was admitted on 08/11/22 with diagnoses including dementia with behavioral disturbances, delusions, chronic obstructive pulmonary disease and diabetes. On 01/24/23 in the afternoon, R15's medication container was observed. A bottle had a label which read Vitamin C 1,000 milligrams (mg) one tablet by mouth twice a day. The physician's order documented, Vitamin C 500 mg one tablet by mouth twice a day. A Medication Administration Record (MAR) dated January 2023, documented the Vitamin C was administered twice daily from 01/01/23 through 01/24/23. On 01/24/23 in the afternoon, Employee #4 (E4) reported R15 received Vitamin C 1,000 mg twice daily. E4 acknowledged Vitamin C 500 mg was not administered as prescribed. E4 indicated being unaware the bottle did not match the physician's order. E4 acknowledged the facility did not clarify the order with the physician to ensure the correct dosage was administered to R15. Severity: 2 Scope: 1 | | | |

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| 0895 SS= D | Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician.<br><br>Inspector Comments: Based on interview and record review, the facility failed to ensure medications on the Medication Administration Record (MAR), were properly signed off on after administration for 1 of 15 residents (Resident #1). Resident #1 (R1) was admitted on 07/01/22 with diagnosis including Alzheimer's disease. The December 2022 and January 2023 MAR's for R1 did not document medication Vitamin D3, 50 micrograms, give once per day were administered on 12/17/22, 12/18/22, 12/24/22, 12/25/22, 01/01/23, 01/07/23, 01/08/23, 01/14/23 01/15/23 and 01/21/23. A Medication Technician indicated the medications were administered to R1, and confirmed the MAR was not signed off on after administration. Severity: 2 Scope: 1 | 0895 | •□□□□□□□□In Service training for all Medication Care Managers will be completed by 3/10/23 and sign in sheets will be uploaded afterwards.<br><br>Aegis's internal policy for Documentation Standards for Medication will be reviewed. Emphasis with Medication Care Team on the 5 rights for passing meds. Right resident, right medication, right dose, right route, right time.<br><br>•□□□□□□□□Re-education complete for Health Services Director detailing the appropriate medication approval processes, specifically defining the three requirements in order to approve; correct supply, corresponding Dr.'s orders and accuracy of EMAR. | 02/17/2023 |
| 1035 SS= F | Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that | 1035 | •□□□□□□□□Community was able to identify a technical issue with employees electronic training records for Alzheimer and Dementia training. This was resolved for all employees of the community on 2/8/2023.<br><br>•□□□□□□□□Of the 4 deficient employees for the 40-hour training requirement; 2 are fully complaint and those records have been uploaded into documents. | 02/17/2023 |

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| | such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family.<br><br>Inspector Comments: Based on interview and document review, the facility failed to ensure two hours of Alzheimer's training was completed within 40 hours of hire, for 4 of 6 employees (Employee #2, #3, #5 and #6). Findings include: Employee #2 was hired on 01/03/22. Review of Employee #2's record did not document the completion of Alzheimer's disease training within 40 hours of hire date. Employee #3 was hired on 08/01/22. Review of Employee #3's record did not document completion of Alzheimer's disease training within 40 hours of hire date. Employee #5 was hired on 09/25/22. Review of Employee #5's record did not document completion of Alzheimer's disease training within 40 hours of hire date. Employee #6 was hired on 10/18/22. Review of Employee #6's record did not document completion of Alzheimer's disease training within 40 hours of hire date. The facility was unable to provide documented evidence Alzheimer's disease training was completed within 40 hours of hire date for Employee #2, #3, #5 and #6 . On 01/24/23 in the morning, the Business Office Manager confirmed there was no documented Alzheimer's training completed within 40 hours of hire for Employee #2, Employee #3, Employee #5 and Employee #6. Severity: 2 Scope: 3 | | o The remaining 2 deficient employees are 50%complete with required training. We estimate completion by: 3/31/2023<br><br>•□□□□□□□□Of the 3 deficient employees for the 90-daytraining requirement; 2 are fully complaint and those records have been uploaded into documents.<br><br>o The remaining employee is 50% complete with the90 days requirement. We estimate completion by: 3/31/2023.<br><br>•□□□□□□□□All remaining employees are being scheduled weekly for dedicated training days. Full completion of all State requirements for Alzheimer's and Dementia training will be complete by 3/31/2023. Training Records will be uploaded on the site.<br><br>•□□□□□□□□Weekly review of training status by department will be conducted every Thursday during the Community's Leadership meeting effective 3/2/2023 and weekly thereafter.<br><br>•□□□□□□□□All New hires will complete all required training prior to assisting any residents. | |

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| 1036 SS= E | Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease.<br><br>Inspector Comments: Based on interview and document review, the facility failed to ensure eight hours of Alzheimer's training was completed within 90 days of hire, for 3 of 6 employees (Employee #2, #5 and #6). Findings include: Employee #2 was hired on 01/03/22. Review of Employee #2's record did not document Alzheimer's disease training was completed. Employee #5 was hired on 09/25/22. Review of Employee #5's record documented one hour of Alzheimer's disease training was completed on 01/09/23 and a half hour was completed on 01/24/23. Employee #6 was hired on 10/18/22. Review of Employee #6's record documented one hour of Alzheimer's disease training was completed on 12/14/22. The facility was unable to provide documented evidence eight hours of Alzheimer's disease training was completed within 90 days of hire date for Employee #2, #5 and #6 . On 01/24/23 in the morning, the Business Office Manager confirmed eight hours of Alzheimer's disease training was not documented as completed within 90 days of hire for Employee #2, #5 and #6. Severity: 2 Scope: 2 | 1036 | •□□□□□□□□Community was able to identify a technical issue with employees electronic training records for Alzheimer and Dementia training. This was resolved for all employees of the community on 2/8/2023.<br><br>•□□□□□□□□Of the 4 deficient employees for the 40-hourtraining requirement; 2 are fully complaint and those records have been uploaded into documents.<br><br>o The remaining 2 deficient employees are 50% complete with required training. We estimate completion by: 3/31/2023<br><br>•□□□□□□□□Of the 3 deficient employees for the 90-daytraining requirement; 2 are fully complaint and those records have been uploaded into documents.<br><br>o The remaining employee is 50% complete with the 90 days requirement. We estimate completion by: 3/31/2023.<br><br>•□□□□□□□□All remaining employees are being scheduled weekly for dedicated training days. Full completion of all State requirements for Alzheimer's and Dementia training will be complete by 3/31/2023. Training Records will be uploaded on the site.<br><br>•□□□□□□□□Weekly review of training status by department will be conducted every Thursday during the Community's Leadership meeting effective 3/2/2023 and weekly thereafter.<br><br>•□□□□□□□□All New hires will complete all required training prior to assisting any residents. | 02/17/2023 |

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| 1045 SS= C | Placard - Display - NAC 449.27704 Placard: Issuance and display; failure to comply. (NRS 449.0302) 2. The administrator shall, within 24 hours after receipt of the placard, display or cause the placard to be displayed conspicuously in a public area of the residential facility.<br><br>Inspector Comments: Based on observation, interview and document review, the facility failed to ensure the most current grade placard was posted. Findings include: On 01/24/23 in the morning, the grade placard posted in the facility was an "A" grade, dated 11/05/19. On 01/24/23 in the afternoon, the Administrator confirmed the posted grade placard was dated 11/05/19 and outdated. Severity: 1 Scope: 3 | 1045 | •□□□□□□□□Updated placard was posted on 2/7/2023 as received by the State. See uploaded photo in documents.<br><br>•□□□□□□□□Business Office Manager will ensure proper placard is posted after the re-survey visit takes place.<br><br>•□□□□□□□□Placard with supporting details of deficiencies has been printed and is available upon request. | 02/07/2023 |
| 1540 SS= F | Cultural Competency Training<br><br>Inspector Comments: Based on interview and record review, the facility failed to: submit an application for a cultural competency training program in compliance with R016-20; and ensure 4 of 6 employees (Employee #1, #3, #4 and #6) were in compliance with Nevada Revised Statues (NRS) 449.103, regarding annual cultural competency training. There was no documented Cultural Competency training for Employees #1, #3, #4 and #6. The Business Office Manager confirmed Cultural Competency training was not provided for Employee's #1, #3, #4 and #6, and acknowledged the facility failed to submit an application for a cultural competency program. Severity: 2 Scope: 3 | 1540 | •□□□□□□□□Of the 4 deficient employees listed, all 4 are now complaint. Supporting documentation is uploaded in documents.<br><br>•□□□□□□□□Community is able to use new State approved vendor Flex Ed as it is a self-paced course.<br><br>•□□□□□□□□Total percentage of completion is 56% with 25employees left to complete. Completion date for 100% compliance is 3/31/2023. Proof of completion will be uploaded on the site.<br><br>•□□□□□□□□All New hires will complete all required training prior to assisting any residents. All remaining employees are being scheduled weekly for dedicated training days to include Cultural Competency.<br><br>•□□□□□□□□Community will ensure annual requirement is met by starting Cultural Competency in December of 2023.<br><br>•□□□□□□□□This mandate has also been added to our internal tracking system for compliance (Kevala). | 02/17/2023 |