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
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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 State Licensure survey completed at your facility on 09/16/24 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files and six employee files 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		
0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees received cardiopulmonary resuscitation (CPR) and first aid training (Employee #3). Findings include: Employee #3 (E3) E3 was hired on 07/26/24 as a Caregiver. E3 completed CPR and first aid training provided by an online company on 03/17/24. The training did not contain an in-person component, a requirement per the regulation. On 09/16/24 in the afternoon, Employee #6 acknowledged the CPR and first aid training completed by E3 did not contain an in-person component, and the employee should have completed training as required by the regulation. Severity: 2 Scope: 1	0106	1) On 9/18/2024, employee #3 attended a CPR class that has in-person component as required and mandated. (Please see attached document). 2) Lead caregiver and Administrator will ensure that all caregivers will attend an actual in-person CPR training course accredited by the American Heart Association initially and every 2 years 3) The Administrator is ultimately responsible in guiding caregivers re schools that offer actual in-person CPR training course accredited by the American Heart Association	09/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
0690 SS= F	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 09/16/24 at 9:45 AM, an oxygen tank was standing upright and unsecured in a bedroom in which three residents were residing. On 09/16/24 in the afternoon, the Administrator acknowledged the tanks should have been secured, per the requirement. Severity: 2 Scope: 3	0690	1) On 9/19/2024, an oxygen tank holder was obtained and all unsecured oxygen tanks of the resident involved were placed inside the holder. 2) Administrator, lead caregivers and all caregivers will ensure that all oxygen tanks are properly secured at all times for safety. 3) The Administrator is ultimately responsible to make certain that oxygen tanks are properly secured at all times for safety. 4) Please see attached document that a picture was taken for oxygen tanks secured in a holder.	09/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	**3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121**

(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
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure an initial physical examination was completed for 1 of 8 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted to the facility on 03/28/23 with diagnoses including stroke- left side weakness, post-traumatic stress disorder (PTSD), depression, and periods of memory. R4's file contained documented evidence of a physical examination conducted on 03/28/23. R4's file lacked documented evidence of an annual physical examination. On 09/16/24 in the afternoon, Employee #6 acknowledged Resident #4's file lacked documented evidence of an annual physical examination. Severity: 2 Scope: 1	0859	1) Resident #4's annual physical examination was inadvertently missed. Information was requested but unfortunately a different document was sent. Lead caregiver is working on obtaining recent physical assessment. 2) Administrator and Lead caregiver will ensure that annual physical assessment is performed as mandated to update every residents' medical condition for the best quality of care. 3) The Administrator is ultimately responsible to make certain annual physical assessment is performed to update the residents' medical condition to give the best quality of care for all residents.	10/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
0870 SS= D	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). Inspector Comments: Based on record review and interview, the facility failed to perform medication reviews every six months for 2 of 8 residents (Residents #5 and #6). Findings include: Resident #5 (R5) R5 was admitted on 11/08/22 with diagnoses including paraplegia and polyneuropathy. R5's medical record contained documented evidence of medication reviews on 05/08/23 and 11/10/23. R5's file lacked documented evidence of a six-month medication review of R5's medications by a physician, pharmacist or registered nurse. Resident #6 (R6) R6 was admitted on 10/07/23 with a diagnosis of stroke. R6's file lacked documented evidence of a six-month medication review of R6's medications by a physician, pharmacist or registered nurse. On 09/16/24 in the afternoon, Employee #6 acknowledged R5 and R6's files did not contain current 6-month medication reviews, per the regulation. Severity: 2 Scope: 2	0870	1) Resident #5 and Resident #6 lacked the documentation of a 6-month medication review. Lead Caregiver is currently working on obtaining the medication verification process from the physicians. 2) Administrator and Lead caregiver ensure that medication verification is completed every 6 months for updates as mandated. 3) The Administrator is responsible to make certain that medication review is completed every 6 months for updates as mandated.	10/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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 , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. 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, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse 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 (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, physician assistant or advanced practice registered nurse 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, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and,	0878	1) Resident #2 has Budesonide 0.5 mg/2ml suspension 1 vial via nebulizer every 12 hrs ordered and medication is in the bin but was inadvertently missed in the MAR. 2) Resident #2 has Fluticasone Propionate 50 mcg/actuation nasal spray ordered, 1 spray for each nostril daily as needed for congestion 3) Both medications were inadvertently not given as ordered by the physician 4) MAR education review were given to all caregivers by the Administrator on 10/10/2024 regarding updated doctors' orders which should accurately be reflected in the MAR as well as the importance of medication reconciliation. 5) Administrator and Lead caregiver will ensure doctors orders are updated and are accurately reflected in the MAR as well as the importance of medication reconciliation. 6) The Administrator is ultimately responsible to make certain that doctors' orders are updated and are accurately reflected in the MAR as well as the importance of medication reconciliation.	10/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
	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. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure medications were administered per physician's orders for 1 of 8 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 07/25/24 with a diagnosis of Acute and Chronic Respiratory Failure with hypoxia. R2's medication bin contained Budesonide 0.5 milligram (mg)/2 milliliter (ml) suspension, use one vial via nebulizer twice a day, dated 07/26/24. A physician order dated 07/25/24 documented Budesonide 0.5 mg/2 ml suspension for inhalation, 1 vial twice a day. R2's September 2024 MAR did not document Budesonide 0.5 mg/2 ml suspension as being administered to R2 twice daily, per the physician's order. The Caregiver explained the facility staff did not administer Budesonide to R2 twice daily as ordered by the physician because the hospice nurse directed the Caregivers to administer the Budesonide only when R2's breathing was difficult. R2's medication bin contained Fluticasone Propionate 50 microgram (mcg) spray, apply one spray into each nostril once a day. A physician order dated 07/25/24 documented Fluticasone Propionate 50 mcg/actuation nasal spray (NOVAPLUS), spray once a day. R2's September 2024 MAR documented Fluticasone 50 mcg /actuation, take one spray on each nostril daily as needed for congestion, PRN (as needed). R2's September 2024 MAR did not document Fluticasone Propionate 50 mcg spray as being administered to R2 as ordered by the physician. On 09/16/24 in the afternoon, the Caregiver acknowledged the September 2024 MAR did not reflect the physician's orders to administer Fluticasone once a day and Fluticasone was not administered per physician's orders. Severity: 2 Scope: 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of	0895	1) Resident #2 has hydrocodone / acetaminophen 5 mg - 325 mg 1 tablet every 8 hrs as needed for pain.	10/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
	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; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 8 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 07/25/24 with a diagnosis of Acute and Chronic Respiratory Failure with hypoxia. R2's medication bin contained Hydrocodone-Acetaminophen 5-325 milligrams (mg), take one tablet by mouth every 4 hours as needed for pain. A physician order dated 07/25/24 documented Hydrocodone Bitartrate/Acetaminophen 5 mg-325 mg tablet, take one tablet every 4 hours as needed for pain. R2' September 2024 MAR documented Hydrocodone/APAP 5/325 mg tablet, take one tablet by mouth every 8 hours as needed for pain. R2's MAR did not accurately reflect the physician's order Hydrocodone Bitartrate/Acetaminophen 5 mg-325 mg tablet, take one tablet every 4 hours as needed for pain. On 09/16/24 in the afternoon, Employee #6 (E6)		2) The medication was not accurately reflected in the MAR (1 tablet every 4 hrs as needed for pain). 3) MAR review were given to all caregivers by the Administrator on 10/10/2024 regarding updated doctors' orders which should accurately be reflected in the MAR as well as the importance of medication reconciliation. 4) Administrator and Lead caregiver will ensure doctors orders are updated and are accurately reflected in the MAR as well as the importance of medication reconciliation. 5) The Administrator is ultimately responsible to make certain that doctors' orders are updated and are accurately reflected in the MAR as well as the importance of medication reconciliation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
	acknowledged R2's September 2024 MAR did not match the physician orders and was not documented accurately for Hydrocodone Bitartrate/Acetaminophen. Severity: 2 Scope: 1			
0936 SS= D	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure 1 of 8 residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441a (Resident #7). Findings include: Resident #7 (R7) R7 was admitted on 03/30/23 with a diagnosis of chronic obstructive pulmonary disease (COPD). R7 completed a Two-Step TB test on 03/10/23. R7's file lacked documented evidence of an annual TB test in 2024. On 09/16/24 in the afternoon, Employee #6 acknowledged R7's file lacked documented evidence of annual TB testing to meet the requirement. Severity: 2 Scope: 1	0936	1) Resident #7 is missing the annual TB test for 2024. 2) Administrator and Lead caregiver will ensure that TB test are done by license provider of resident annually. 3) The Administrator is ultimately responsible to make certain that TB test are done annually by license provider of a resident. Addendum: 1) Letter on 10/17/24 addressed TB test results or quantiferon test can be done on the residents. 2) TB test was done on 9/25/24 and read 9/27/24 with negative result after the survey on 9/16/24. Addendum: 11/21/24 1) Please see attached quantiferon test result.	11/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121

(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
0995 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 lock a gate leading to the street. Findings include: On 09/16/24 at 9:55 AM, the gate leading from the back yard to the front yard, which led to a street, did not have a lock. On 09/16/24 at 9:55 AM, Employee #6 acknowledged the gate should have had a lock. Severity: 2 Scope: 3	0995	1) During the survey, the facility inadvertently failed to lock the gate leading to the street. 2) The Administrator and Lead caregiver reviewed the protocol for safety which includes keeping the gate always locked as mandated to all caregivers. 3) The Administrator, Lead caregiver. and all caregivers will ensure that the gate leading to the street is always locked as mandated. 4) the Administrator is ultimately responsible to make certain that the gate leading to the street is always locked as mandated.	11/21/2024
1700 SS= E	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to	1700	1) Residents #4, #5 and #7 lacked documented evidence of an initial and /or current placement in their files. 2) The Administrator and Lead caregiver will ensure documents regarding esident placements are obtained from the provider. 3) The Administrator is ultimately responsible to make certain documents regarding resident placements are obtained from the provider. Addendum: 11/21/24 1) Please see attached latest placement determination for above residents #4, #5, and #7	11/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	**3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121**

(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
	conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on interview and record review, the facility failed to ensure an annual placement assessment and/or initial placement assessment was obtained for 3 of 8 residents (Residents #4, #5, and #7). Findings include: Resident #4 (R4) R4 was admitted to the facility on 03/28/23 with diagnoses including Stroke-left side weakness, Post-Traumatic Stress Disorder (PTSD), depression, and Periods of Memory. R4's file lacked documented evidence of an initial and a current placement assessment by R4's physician. Resident #5 (R5) R5 was admitted to the facility on 11/18/22 with diagnoses including paraplegia and polyneuropathy. R5's file			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10740	A. BUILDING _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	**3784 EDISON AVENUE, LAS VEGAS, NEVADA ,89121**

(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
	contained a placement assessment by R5's physician dated 11/12/22. R5's file lacked documented evidence of a current placement assessment by R5's physician. Resident #7 (R7) R7 was admitted to the facility on 03/30/23 with a diagnosis of chronic obstructive pulmonary disease (COPD). R7's file contained a placement assessment by R7's physician dated 03/30/23. R7's file lacked documented evidence of a current placement assessment by R5's physician. On 09/16/24 in the afternoon, Employee #6 acknowledged R4, R5, And R7's files did not contain initial and/or current physician placement assessments. Severity: 2 Scope: 2			