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
	10911	A. BUILDING _____ B. WING _____	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTA CARE HOME	2007 ALTA DRIVE, LAS VEGAS, NEVADA ,89106

(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 07/01/2024, 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 persons with mental illness, Category II residents. The census at the time of the survey was eight. Eight 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiency was identified:	0000		
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 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 interview and record review, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/18/24, with diagnoses including hypertension. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 03/30/24 with diagnoses including chronic obstructive pulmonary disease and psychosis. R2's file lacked a person-	0515	Tag 0515: (A) After survey administrator prepared a service plan per mandate by the State regulation. Their respective nurses were likewise consulted. (B) Service Plan shall be discussed during the next caregiver's meeting to ensure proper implementation of; (C) Administrator shall go over Service Plans and monitor compliance during his regular monthly walk through; (D) Person responsible : Administrator (E) Date of Completion: August 12, 2024 Attachment: Sample copy of Facility Care Plan	08/12/2024

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	centered service plan. Resident #3 (R3) R3 was admitted to the facility on 07/22/21, with a diagnoses including history of pneumothorax and chronic tremors. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 04/25/24, with a diagnoses including hypertension and diabetes. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 06/18/24, with diagnoses including encephalopathy and bipolar. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 09/20/23, with diagnoses including hypertension and encephalopathy. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 09/09/23 with diagnoses including hypertension and malignant neoplasm of the brain. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted to the facility on 03/24/23, with a diagnoses including hypertension and anemia. R8's file lacked a person-centered service plan. On 07/201/24 in the afternoon, a Caregiver acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7, and R8. Severity: 1 Scope: 3			