STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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 10/17/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for seven 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 five. Five resident files and five 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 deficiencies were identified:	0000		
0870 SS= F	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).	0870	Administrator will review and sign all 6 month medication reviews for all Residents going forward on an ongoing basis at least monthly. All 6 month med reviews were reviewed and completed on 10/25/2024.	10/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	Inspector Comments: Based on interview and record review, the facility failed to ensure six month medication reviews were reviewed and signed off by the Administrator, for 4 of 5 residents (Resident #2, Resident #3, Resident #4, Resident #5). Findings include: Resident #2 (R2) R2 was admitted on 07/03/23 with hypertension and diabetes mellitus type 2. Medication reviews for R2 dated 07/24/24 and 01/24/24 were not reviewed or signed off by the Administrator. Resident #3 (R3) R3 was admitted on 10/31/22 with diabetes mellitus type 2 and dementia. Medication reviews for R3 dated 05/12/24 and 11/16/23 were not reviewed or signed off by the Administrator. Resident #4 (R4) R4 was admitted on 06/03/17 with Parkinson's disease an vitamin D deficiency. Medication reviews for R4 dated 06/24/24 and 01/21/24 were not reviewed or signed off by the Administrator. Resident #5 (R5) R5 was admitted on 06/28/19 with hypertension and dementia. Medication reviews for R5 dated 10/24/24 and 04/04/24 were not reviewed or signed off by the Administrator. On 10/17/24 in the morning, a Manager confirmed the Administrator had not reviewed or signed off on six month medication reviews for R2, R3, R4 or R5. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
1840 SS= D	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on interview and record review, the facility failed to ensure Infection Control training for unlicensed caregivers was completed for 2 of 5 employees (Employee #4 and Employee #5). Findings include: Employee #4 (E4) E4 was hired on 11/30/17 as a Caregiver. There was no documented Infection Control training found in the record of E4. Employee #5 (E5) E5 was hired on 12/23/19 as a Caregiver. There was no documented Infection Control training found in the record of E5. On 10/17/24 in the morning, a Manager confirmed there was no Infection Control training in E4 and E5's employee records. Severity: 2 Scope: 1	1840	Employees E4 & E5 completed their CDC annual training on 10/17/2024. Administrator and/or Designee will monitor on a monthly basis or as needed to ensure all staff have their annual CDC trainings going forward.	10/17/2024