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 |
|---|---|---|---|
| | 155 | A. BUILDING _____ B. WING _____ | 09/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE HOME | 7560 SILVER LEAF WAY, LAS VEGAS, NEVADA ,89147 |

| (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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and a focused infection control State Licensure survey completed at your facility on 09/26/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight 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 three 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 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROMEO BALGAN | Title: Administrator | Date: 10/14/2022

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| 1540 | Cultural Competency Training<br><br>Inspector Comments: Based on interview and record review, the facility failed to submit to the Division a cultural competency course/training program or provide documented evidence of a contract with a third party, to develop and operate the program for cultural competency training for 3 of 3 employees (Employee #1, #2 and #3) Findings include: Employee #1 (E1) E1 was hired on 09/30/12 as a Caregiver. E1's file lacked documented evidence of initial cultural competency training. Employee #2 (E2) E2 was hired on 09/20/22 as a Caregiver. E2's file lacked documented evidence of initial cultural competency training. Employee #3 (E3) E3 was hired on 02/16/16 as a Caregiver. E3's file lacked documented evidence of initial cultural competency training. On 09/26/22 at 11:00 AM, the facility Administrator confirmed E1, E2 and E3's employee files lacked documented evidence cultural competency training was completed. Severity: 2 Scope: 3 | 1540 | Tag 1540 Cultural Competency Training<br><br>1). The Division has implemented a new added requirements for all employees to develop and operate the Program for Cultural Competency for Employees Training. All the employees have taken the course and that encompasses diversity, equity and inclusion for Race, Color, Religion, Sexual Orientation, Language and Ethnicity.<br>2). Employees must understand, act and process of discrimination and everything that is respectful to others.<br>3). Employees must work together and with the help and assistance of the Facility Manager and Supervisor will ensure the Deficient Practice will not recur.<br>4). Facility Administrator is the responsible person, will guide the employees and together with the aid and assistance of the Facility Manager will work together to ensure the Plan of Correction is implemented.<br>5). 09/21/2022 ; 10/08/2022 ; 10/14/2022<br>6). See Appendix A1, A2, A3, A4, and A5 | 10/14/2022 |