DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**08/07/2024**

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 Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation completed at your facility on 08/07/24, 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 four employee files were reviewed. The facility received a grade of B. There was one complaint investigated: Substantiated: 1. Complaint #NV00071405 was substantiated. (See TAG Y0104) Observations of facility staffing and residents receiving care and assistance and tours of the facility. Interviews were conducted with residents, the Facility Manager and the Administrator. Four employee files were reviewed. 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		
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview and record review, the facility failed to ensure a background check was completed for the correct facility and every five years through the Nevada Automated Background	0104	Tag # 0104 Personnel Files Backgrounds Checks NAC 449.200 1.) The NABS system has been updated and both Employee #1 and Employee #4 were cleared 2.) The deficient practice does not recur because both employees has long been working for so many years 3.) Every six (6) months Facility Administrator will check the files of every residents and employees to make sure Files are current and updated 4.) Administrator is responsible for	09/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ROMEO V BALGAN Title: Administrator Date: 10/21/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Check System (NABS) for 2 of 4 employees (Employee #1 and #4). Findings include: Employee #1 (E1) E1 was hired on 01/15/99 as the Administrator. E1 had no documented evidence of a background check completed through NABS for this facility. The Administrator was listed as "Eligible not Employed" for the facility in the NABS system. The Administrator's record contained a final registry record dated 10/04/22 from a different facility. On 08/07/24 in the afternoon, the Administrator acknowledged their background check had not been completed for this facility and verbalized they had completed it at their other facility. Employee #4 (E4) E4 was hired on 10/01/12 as a Caregiver. The NABS system documented E4 had fingerprints taken on 01/09/19 with a determination date of 01/11/19 which was 5 years ago. E4 had no documented evidence that E4's background check had been completed every five years as per the requirement. E4 was listed as "Eligible - Expired" for the facility in the NABS system. On 08/07/24 in the afternoon, the Administrator verbalized having sent E4's fingerprints to the wrong destination on 07/17/24 and acknowledged E4's background check had expired. A letter dated 07/22/24 from the Bureau's Background Check Coordinator documented the Administrator needed to complete and submit the pending applications and then send the fingerprint cards to the Nevada Department of Public Safety. Severity: 2 Scope: 2 Complaint# NV00071405 This is a repeat deficiency from the 08/16/23 annual survey.		ensuring POC is implemented 5.) Employee #1 - 08/02/2024 Employee #4 09/01/2024 6.) See Attachment "A"	

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the backyard was clean and well maintained. Findings include: The following observations were made in the afternoon of 08/07/24 in the backyard: - An unused motorized scooter with multiple cardboard boxes used to collect recyclables - A dresser - A white desk - A wheelchair - Two empty shopping carts - A wooden entertainment center - 4 wheelchairs - 2 commodes - An exercise bike - 2 walkers - A twin size mattress, boxspring and bedframe - Side rails for a bed - 2 canes - 2 rusted containers of paint On 08/07/24 in the afternoon, the Administrator acknowledged the backyard was not clean and well maintained. Severity: 2 Scope: 3 This is a repeat deficiency from the 08/16/23 annual survey.	0178	TAG # 0178 Health & Sanitation NAC 449.209 1.) The backyard was cleaned and well maintained. four wheelchairs were donated. an exercise bike which was used by residents has taken away and will be replaced usable bedframe has been thrown away including its mattress. Also, 2 canes side rails for hospital bed were donated. 2.) A metal hauler friend has been contacted and picked up all metals needed for recycling others were donated. 3.) The Facility Administrator with the help of caregivers will need to maintain the cleanliness of the Facility 4.) Administrator is responsible for ensuring the POC is implemented 5.) 08/10/2024 6.) See attachments "B"	09/14/2024
0515 SS= C	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,	0515	TAG # 0515 Supervision and Treatment of Residents NAC 449.259 & R043-22 1.) Residential Facility shall ensure that the Staff collaborate with each Residents as well as Family and Health Care professionals to develop a service plan for each Resident and review the Service Plan every year. 2.) All Facility Residents must each have the person centered service plan and should coincide with the Service Plan derived and given to their Social Worker in the Aging Disability and Service Division since most of them are Medicaid Recipients. 3.) Facility Administrator will provide and make the Service Plan and Facility Staff	09/14/2024

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	#5, #6, #7 and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/07/16, with a diagnosis of seizure disorder. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 012/21/20 with diagnoses including hypertension, epilepsy and dementia. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on 03/16/19, with a diagnosis of Alzheimer's disease. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 01/31/24, with diagnoses including hypertension and traumatic brain injury. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 07/05/21, with diagnoses including hyperlipidemia and hypertension. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 12/23/23, with diagnoses including chronic obstructive pulmonary disease and hypertension. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 09/01/23, with diagnoses including spondylosis and chronic obstructive pulmonary disease. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted to the facility on 04/09/14, with diagnoses including acute kidney disease and hypertension. R8's file lacked a person-centered service plan. On 08/07/24 in the afternoon, the Administrator acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7 and R8. Severity: 1 Scope: 3		shall collaborate with each Resident. 4.) The Administrator of the Facility is responsible for ensuring the Plan of Correction is implemented and review it once a year. 5.) August 11, 2024 6.) See attachments "C'	
1830 SS= E	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for	1830	TAG # 1830 Infection Control Training LCB File no. R048-22 Sec. 54 1.) Employee #1 has learned lately about this Professional Infection control training for Doctors and Nurses in Hospitals usage. Employee # 1 has emailed the tests taken and certificates earned on modules 1 -15.	09/14/2024

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	Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control staff completed 15 hours of approved infection control training (Employees #1 and #2). Findings include: Employee #1 (E1) E1 was hired as an Administrator on 01/15/99. On 08/07/24 in the afternoon, the Administrator identified themselves as the primary infection control staff. E1's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. Employee #2 (E2) E2 was hired as a Facility Manager on 01/15/99. On 08/07/24 in the afternoon, the Administrator identified E2 as the secondary infection control staff. E2's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. On 08/07/24 in the afternoon, the Administrator confirmed neither E1 nor E2 had completed the required 15 hours of infection control and prevention training from an approved organization. Severity: 2 Scope: 2		Designated Employee #2 has reviewed and taken a lot of time and managed to finished the approved training. And taken the required certificates needed for compliance. 2.) After taking the trainings both Employees #1 and #2 certificates were now added to their personnel files for keeps. 3.) Corrective actions will be monitored by Administrator to ensure the deficient practice will not recur. 4.) The Facility Administrator is responsible for ensuring the plan of correction is implemented and share this to other employees. 5.) Employee **#** 1 finished the course on 08/09/2024 Employee #2 finished and completed the course on 08/11/2024 6.) See attachements **#** D number 1 and **#**D number 2	