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
	1970	A. BUILDING _____ B. WING _____	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS ALZHEIMER AND MEMORY CARE 1	3224 BRAZOS STREET, LAS VEGAS, NEVADA ,89169

(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 11/14/23 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten 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 nine. Nine resident files and four employee files were reviewed. The facility received a grade of B. 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		
0253 SS= F	Adequate Supplies of Food - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure a two day supply of fresh fruits and vegetables were available for 9 of 9 residents. Findings include: On 11/14/23 at 9:30 AM, the refrigerator contained five long sticks of celery. On 11/14/23 at 9:30 AM, the Caregiver acknowledged there were no other fruits or vegetables on site and it was not enough for a two day supply for nine residents. Severity: 2 Scope: 3	0253	1. The administrator got delayed in delivering the fruits and vegetables. The supply were brought later in the afternoon. 2. The staff must place an order of fruits and vegetables 2 or 3 days before running out. 3. The staff must ensure that there are enough supply of fruits and vegetables in stock in the facility. 4. The staff/main caregiver. 5. 11/14/2023 6. Pictures attached.	11/14/2023

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: TOLENTINO I. TAN Title: Administrator Date: 11/23/2023

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 9 residents signed an ultimate user agreement authorizing the facility to administer medications to residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 11/28/22 with a diagnosis of dementia. R2's file was missing a signed ultimate user agreement authorizing the facility to administer medications to the resident. On 11/14/23 at 9:30 AM, the Caregiver acknowledged R2 did not have a signed ultimate user agreement. Severity: 2 Scope: 1	0876	1. The facility reached out to family multiple ways regarding the admission packet but failed to return it. Administrator asked the family to personally come down and sign the ultimate user agreement for the resident. 2. The administrator must ensure that the agreement is signed on the admission day. 3. The administrator must ensure that all forms in the admission packet is signed and kept in the resident's file. 4. The administrator. 5. 11/15/23 6. Form attached.	11/15/2023
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the	0878	1. Staff called physician to get a script for resident's Ondansetron but the medication was discontinued day before. Copy of order was faxed to facility 11/15/23. 2. Staff must ensure that supply of medication is on hand and if discontinued secure an order and keep in resident's file. 3. Staff must monitor that all medication is on hand and if discontinued, must have written discontinue order on file and MAR. 4. Main caregiver/med tech. 5. 11/15/23. 6. DC order attached.	11/15/2023

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	physician. If a physician 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 (Previously Y 0879) (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 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, the physician, registered nurse or pharmacist must interpret that order or prescription and, 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 medication was on site for 1 of 9 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/06/12, with a diagnosis of chronic kidney disease. A physician's order dated 10/23/23, and the November 2023 Medication Administration Record (MAR) documented Ondansetron 4 milligrams (mg), take one tablet by mouth every eight hours as needed for nausea. The medication was not on site. On 11/14/23 at 11:30 AM, the Caregiver acknowledged the medication was not on site and should have been. The Caregiver indicated R1 had not recently had symptoms of nausea and had not requested the medication. This was a repeat deficiency from the 11/14/23 State Licensure survey. Severity: 2 Scope: 1			

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were secured. Findings include: On 11/14/23 at 9:30 AM, there was unsecured dishwasher detergent, multi-purpose cleaner, and dish soap in the kitchen cabinet under the sink and there was no lock on the cabinet to secure the toxic substances. On 11/14/23 at 9:30 AM, the Caregiver acknowledged the unsecured toxic substances and reported it should have been locked up. Severity: 2 Scope: 3	0999	1. Staff moved the dishwasher soap, multi-purpose cleaner and dish soap in the locked room while waiting for the handyman to put a lock on the cabinet under the sink. 2. Staff must place all toxic substances in a locked room/cabinet after each use. 3. Staff must ensure all toxic substances are stored in a locked room/cabinet after use. 4. Staff/main caregiver. 5. 11/15/23. 6. Picture attached.	11/15/2023

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1540 SS= D	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees received cultural competency training (Employee #1). Findings include: Employee #1 (E1) E1 was hired on 07/12/21 as a Caregiver. E1's file lacked documented evidence of cultural competency training. On 11/14/23 11:00 AM, the Caregiver acknowledged E1 did not receive cultural competency training. This was a repeat deficiency from the 11/14/23 State Licensure survey. Severity: 2 Scope: 1	1540	1. Employee #1 was registered for the Nov. 17th Cultural Competency Training by NVHCA. 2. Administrator must ensure all training are completed by the employee and records kept in file. 3. Administrator must monitor all required training are completed and records/certificates are kept in file. 4. Administrator. 5. Attended training 11/17/23, certificate generated 11/23/23. 6. Certificate attached.	11/17/2023