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
	2275	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN CENTER, LLC 1	11 WHITEWIND LANE, LAS VEGAS, NEVADA ,89110

(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 the Annual State Licensure Grading survey and COVID-19 Infection Control Inspection conducted at your facility on 07/16/21, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility was licensed for 10 Residential Facility for Group beds for persons with Alzheimer's disease or related dementia, Category II residents. The census at the time of the survey was eight. Eight resident records and five employee records were reviewed. The facility received a grade of B. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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 regulatory deficiencies were 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: MARIA FE ANTONIO Title: Administrator Date: 08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2275	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN CENTER, LLC 1	11 WHITEWIND LANE, LAS VEGAS, NEVADA ,89110

(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
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, document review, and interview, the facility failed to implement and maintain an effective Infection Control and Prevention Plan in response to the COVID-19 Pandemic. Findings include: -On 07/16/21 at 10:30 AM, one of two visitors was not screened with a temperature check and a COVID-19 symptoms check prior to entry. -Two of two visitors did not wear a face mask. -There were no N95 masks available at the facility. The Administrator verbalized it was the facility's policy to screen all persons entering the facility with a temperature check and a symptoms questionnaire, and all visitors must wear face masks while at the facility. The facility's Infection Control and Prevention Plan documented all visitors must be screened and put on a face mask prior to entry. Severity: 2 Scope: 3 Repeat Deficiency: 09/04/20	0050	a) The staff on duty was reminded to always take temperature check and a COVID 19 symptoms check to all visitors prior to entering the facility. All staff were reminded to tell all visitors to put on mask when inside the facility, whether vaccinated or unvaccinated. The facility now has a supply of N95 masks, and one of the staff member had been medically cleared and fit tested to wear an N95 mask. b) A poster can be seen at the entrance door that would remind all individuals to wear mask before entering the facility. (Attachment#1, Tag 0050) The administrator will conduct meeting periodically with all employees to discuss the Infection Control Policies of the facility. Staff on duty will always perform temperature & COVID 19 symptoms check to all visitors. Administrator will issue a disciplinary action for non-compliance. c) July 20, 2021	08/22/2021
0820 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or (c) The wound is the result of surgical intervention and care is provided as	0820	a) A written request for permission to retain Resident#8 as a resident of our facility was approved.(Attachment#2, Tag 0820) Treatment plan from Professional Wound Specialist is now on file.(Attachment#3, Tag 0820) The new order for Mupirocin 2% ointment and Hydrogel is now on file. (Attachment#4, Tag 0820) b) All resident files with tracheostomy or open wound will be reviewed monthly to ensure all records are current and contain accurate documentation to meet the regulatory requirements. All medications will be reviewed as well to make sure that the instruction on the label is correct. The administrator will monitor for compliance.	08/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2275	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN CENTER, LLC 1	11 WHITEWIND LANE, LAS VEGAS, NEVADA ,89110

(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
	directed by the surgeon. Inspector Comments: Based on observation, interview, and record review, the facility failed to provide documentation that a resident's open wound was in a healing condition and the treatment plan was consistent with the care for 1 of 8 sampled residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted to the facility on 05/13/21 with diagnoses including dementia and history of cerebral vascular accident. R8 was admitted with an open wound (stasis ulcer) on the right lower extremities. There was no documented evidence the wound was in a healing condition. The medication box for R8 contained one ointment (Mupirocin 2% ointment, apply to wound topically once a day) and one gel (Hydrogel, apply to wound daily). The labels on the medications documented an order date of 06/11/21. On 07/16/21, the Nurse Practitioner (NP) verbalized the wound care orders upon readmission on 05/13/21 were once weekly by the physician extender, and two times weekly and as needed when soiled by a registered nurse. The NP indicated the administration instructions of the Mupirocin and the Hydrogel were incorrect, and should have been consistent with the three times weekly administration by a registered nurse and physician extender. The Nurse Practitioner indicated the wound should only be cared for and treated by the physician extender and the registered nurse. The facility Caregivers should not apply ointment or gel. The Administrator acknowledged the facility did not obtain the wound treatment plan from the Hospice, and the medication label instructions for daily application of the ointment and the gel were inconsistent with the scheduled days of physician and registered nurse visits. There was no wound treatment plan in R8's file. Severity: 2 Scope: 1		c) August 20, 2021	
0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility	0905	a) Resident#2 medication box containing Ipratropium-Albuterol has the correct order now. (Attachment#5, Tag 0905) Resident#2 MAR for all her PRN medications is attached.(Attachment#6, Tag 0905) Resident#6 is no longer a resident of our	08/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2275	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN CENTER, LLC 1	11 WHITEWIND LANE, LAS VEGAS, NEVADA ,89110

(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
	shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on interview and record review, the facility failed to ensure medication administered on an as-needed basis had a physician's order with a specific amount of the medication for 2 of 8 sampled residents (Residents #2 and #6). Findings include: Resident #2 (R2) R2 was admitted to the facility on 06/01/19 with diagnoses including dementia and chronic kidney disease stage 3. The medication box for R2 contained Albuterol Ipatroprium Sulfate, 1-2 puffs every four hours as needed for shortness of breath. The Administrator and Employee #2 acknowledged the physician's order should have documented a specific number of puffs of the Albuterol. Resident #6 (R6) R6 was admitted to the facility on 03/07/21 with diagnoses including protein malnutrition, hypertension, and history of hydrocephalus. The hospice physician's order dated 06/11/21 for the Ibuprofen documented 200 milligrams (mg), take 1 - 2 tablets every four hours as needed for pain. The hospice physician's order dated 06/11/21 for Oxygen documented to administer via nasal cannula, 2 - 4 liters as needed for shortness of breath. The Administrator and Employee #2 acknowledged the physician's orders should have documented a specific number of tablets of the Ibuprofen to be taken, and a specific amount for the Oxygen liters to be administered. Severity: 2 Scope: 1		facility. She moved out last July 25, 2021 to Maryland to be with her daughter. b) Whenever the residents are seen by their physicians, the physician's prescription order will be reviewed concerning the resident's as needed medications. The physician's prescription order for as needed medications should contain written instructions indicating the following: 1) the specific symptom for which the medication is to be given 2) the exact amount of medication that may be given 3) the frequency with which the medication may be given. The administrator will monitor for compliance. c) July 20, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2275	A. BUILDING _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN CENTER, LLC 1	11 WHITEWIND LANE, LAS VEGAS, NEVADA ,89110

(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
0938 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to complete an activities of daily living evaluation annually for 5 of 8 sampled residents (Residents #1, #2, #3, #4, and #7). Findings include: There was no documented evidence of an annual activities of daily living (ADL) evaluation for Resident #1 (R1 - admitted 03/31/19), Resident #2 (R2 - admitted 06/01/19), Resident #3 (R3 - admitted 08/21/19), Resident #4 (R4 - admitted 10/31/18), and Resident #7 (R7 - admitted 12/15/18). The Administrator acknowledged an activities of daily living evaluation was not completed within the last 12 months for R1, R2, R3, R4, and R7. Severity: 2 Scope: 3	0938	a) Resident#1,2,3,4 & #7 activities of daily living evaluation is now on file. (Attachment#7,8,9,10 & 11, Tag 0938) b) The administrator will ensure that resident's activities of daily living evaluation is done annually and upon admission. The administrator will check on a monthly basis resident's files to ensure all records are current and contain accurate documentation to meet regulatory requirements. c) July 16 2021	08/22/2021