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
	2406	A. BUILDING _____ B. WING _____	12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY ADULT CARE	**1905 QUAIL POINT COURT, LAS VEGAS, NEVADA ,89117**

(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 conducted at your facility on 12/26/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for persons with Alzheimer's, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and two 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 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		
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 a bathroom sink was free of rust; kitchen equipment was free from food debris; and the backyard was free of clutter and trash. There was trash bags pilled up and ripped chairs in backyard. A caregiver indicated the items in the bathroom were in need of repair and confirmed the exterior chairs were unusable and trash bags would be removed. Severity: 2 Scope: 3	0178	1.) Citation will be corrected by clearing backyard of cited objects, repairing sink of rust, and evaluating and cleaning kitchen equipment. 2.) Ownership and caregivers will be informed of the need to maintain environmental standards in accordance to BHCQC standards. All staff members will be responsible for keeping an eye out on any possible obstructions or citations, and will alert the proper authorities. Administrator will evaluate environmental standards upon each visit, at least once a month. 3.) All staff members will be responsible for upkeep of the facility. Caregivers will be responsible for alerting the home owner of needed repairs to stay in compliance with BHCQC regulations. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 2/8/2020.	02/08/2020

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: ROBERT MARTINEZ Title: Administrator Date: 02/13/2020

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to provide annual physical examination results for 1 of 5 residents (Resident #4). Severity: 2 Scope: 1	0859	1.) Citation will be corrected by obtaining a physical exam for Resident #4 as soon as possible. 2.) Evaluation of resident files will be done on a more regular basis (beginning of each month) so due dates for physical exams can be completed in a timely manner before they are due. Physical exam due dates will be written down and dispensed to caregivers and ownership so everyone will know when each resident's physical exam is due. 3.) Administrator will review physical exam due dates for each resident at the beginning of each month. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 2/3/2020.	02/03/2020

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0870 SS= E	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). Inspector Comments: Based on record review and interview, the facility failed to ensure a pharmacy review was completed at least once every six months for 4 of 5 residents (Resident #1, #2, #4 and #5). Severity: 2 Scope: 2	0870	1.) Corrective action will be taken by ensuring ownership and caregivers know the exact 6 month due date for each resident's next Med Review. 2.) Caregivers will be informed that MED REVIEWS are due every 6 months. Med review due dates for each resident will be written down and dispensed to caregivers and ownership. 3.) Administrator will ensure med reviews are completed within the 6 month due date by regularly monitoring and evaluating resident med review due dates on a monthly basis. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 2/3/2020.	02/03/2020

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0938 SS= D	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 ensure an Activities of Daily Living (ADL) Assessment was completed upon admission and/or annually thereafter for 2 of 5 residents (Resident #2 and #3). Findings include: Resident #2 was admitted to the facility on 12/31/18 with diagnoses including dementia, hypertension and coronary artery disease. Resident #2's file lacked documented evidence of an initial ADL assessment for 2018. The last documented ADL assessment was dated 12/2019. Resident #3 was admitted to the facility on 02/25/19 with diagnosis including dementia, psychosis and diabetes. Resident #3's file lacked documented evidence of an initial ADL assessment for 2019. The Administrator verbalized the assessment must have been missed and was aware it needed to be completed at least annually. Severity: 2 Scope: 1	0938	1.) Citation will be corrected by ensuring ADL's will be completed upon admission of any new resident. 2.) Initial and annual ADL's will be monitored for each resident, with caregivers and management being made aware of pending due dates by the Administrator. 3.) Administrator will evaluate each new resident's file upon admission, ensuring an ADL is completed upon admission date. Annual ADL due dates will be written down, dispensed to caregivers and management, and followed up by the Administrator on a regular basis. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 2/3/2020.	02/03/2020

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0991 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: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm worked on one exit door when opened. The exit door leading to the backyard did not trigger an audible alarm when opened. The caregiver explained the alarm was not working and should have been replaced. Severity: 2 Scope: 3	0991	1.) Citation will be corrected by making sure the door alarm is turned ON at all times. 2.) Door alarm was functional during the survey. It was in the "off" position due to caregivers constantly opening the door for laundry purposes as well as to enter the garage for items. Caregiver and surveyor simply did not test the efficacy of the alarm during the survey. However, it is fully operational with a working battery and alarm sound. 3.) Administrator and management will check on the door alarm on each visit to make sure it is "on" at all times. Caregivers will be notified of how to turn it "on" and "off" as well. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 2/3/2020.	02/03/2020