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
	2726	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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 08/23/23, 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 elderly and disabled persons, and/or mental illnesses, Category II residents. The census at the time of the survey was six. Six resident files and four 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following 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: BELMA DIZON | Title: MANAGING MEMBER | Date: 10/02/2023

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure all medications for 1 of 6 residents were properly labeled with a resident's name, prescribing physician, and directions for use. (Resident #2) Findings include: Resident #2 (R2) R2 was admitted on 11/09/21 with diagnoses including type 2 diabetes. On 08/23/23 in the afternoon during a review of resident medications, surveyor observed 6 boxes of glucose strips (50 per box) and 3 boxes of lancets (100 per box), in a cabinet where the resident medications were stored. The boxes of glucose strips and lancets lacked a resident name prescribing physician, and directions for use on the packages. The facility's Medication Procedures policy (undated), documented over the counter medications must have the resident's name written on the container. Prescription medication must be kept in its original container with the resident's name, ordering physician, dosage and frequency. On 08/23/23 in the afternoon, Employee #2 confirmed the boxes of glucose strips and lancets belonged to R2 and had no resident name, prescribing physician's name or directions for administration on the packages. Employee #2 acknowledged the medications for R2 should have had labels on the packages. Severity: 2 Scope: 1	0923	1. Managing Member removed 6 boxes of glucose strips and 3 boxes of lancets from medication cabinet on the day of the survey. 2. Administrator and Managing member will ensure all medications, including over the counter medications, have labels containing resident's name, ordering physician, dosage, and frequency. 3. Administrator and managing member will monitor for compliance. 4. Administrator and managing member are responsible for ensuring the POC is implemented. 5. 09/20/2023	09/20/2023

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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 were in compliance with Nevada Revised Statutes (NRS) 449.103, regarding initial cultural competency training. (Employee #3) Findings include: Employee #3 (E3) E3 was hired on 05/18/23 as a Caregiver. E3's file lacked documented evidence of initial cultural competency training. On 08/23/23 at 10:35 AM, Employee #2 acknowledged E3's file lacked documented evidence of initial cultural competency training and confirmed E3 should have had the initial cultural competency training within 30 days of hire. Employee #2 confirmed the facility did not have a policy regarding cultural competency training. Severity: 2 Scope: 1	1540	1. Employee #3 finished cultural competency training on 09/19/2023. Employee #3 has received the cultural competency training completion certificate as of 09/19/2023. 2. Administrator and managing member will mandate cultural competency training be finished within 30 days of hire of new staff. 3. Administrator and managing member will monitor for compliance. 4. Administrator and managing member are responsible for ensuring the plan e of correction is implemented. 5. 09/20/2023 6. Please see attachment.	09/20/2023

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1600 SS= C	Preferred Name/Pronoun P& P - R016-20 Section 19.1 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. Inspector Comments: Based on record review and interview, the facility failed to ensure there were policies developed and resident records revised in compliance with R016-20 Section 19, regarding resident records to reflect resident gender identity or expression and preferred name; and R016-20 Section 20, regarding reasonable accommodations in providing statements and information to residents unable to read and/or speak English, are blind or visually impaired or have communication impairments. Findings include: A review of residents records for #1, #2, #3, #4, #5 and #6, documented no revisions to the records to reflect gender identity or expression and preferred name. The facility had no revised policies to be in compliance with R016-20 Section 19 and R016-20 Section 20. On 08/23/23 in the afternoon, Employee #1 confirmed there were no updated policies or changes to resident records to reflect the new regulations. Severity: 1 Scope: 3	1600	1. The facility has created policy and forms to reflect resident's gender identity, expression, and preferred name. Residents have been informed they can refuse to answer and that information asked from them is to provide a better care for them. 2. Facility's policy is to have forms filled out upon admission and for those who are current residents of facility. 3. Management will ensure to check forms for all current residents and upon admission of new residents. Management will monitor for compliance. 4. Administrator and managing member are responsible for ensuring the POC is implemented. 5. 09/20/2023 6. Please see attachments	09/20/2023