

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2787	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2019
NAME OF PROVIDER OR SUPPLIER MEADOWS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MEADOWS LILLY AVE, LAS VEGAS, NEVADA ,89108		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State licensure annual survey conducted in your facility on 12/11/19. This State licensure survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed to provide care to eight elderly and/or disabled residents with endorsements for chronic illness and/or mental illness, Category II beds. The census at the time of the survey was six. Six resident files were reviewed and three 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:	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0936 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure an annual tuberculosis test (TB) was completed for 1 of 8 sampled residents (Resident #5). Severity: 2 Scope: 1	0936	0936 1) Resident #5 had an annual tuberculosis test (TB) a day after the survey, 12/12/19, and read on 12/14/19. Attachment #1 0936 2) Administrator/owner will always check residents/employees files for updated TB tests. 3) Administrator/owner will monitor for compliance. 4) Administrator/owner are responsible for ensuring plan of correction implemented. 5) 12/18/19 6) Attachment #1 0936	12/18/2019

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 Name: MARINA VAUGHN Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 12/18/2019