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
	2787	A. BUILDING _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS CARE HOME	**5125 MEADOWS LILLY AVE, LAS VEGAS, NEVADA ,89108**

(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 FOCUSED COVID-19 Infection Control survey conducted at your facility on 01/19/21, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for eight Residential Facility for Group beds, with endorsements for mental illness and chronic illness, Category II. The census at the time of the survey was eight. The facility received a grade of A. The Caregiver verbalized no residents or employees tested positive for COVID-19 or displayed signs or symptoms of COVID-19. The focused COVID-19 Infection Control survey included the following: Observations: -On 01/19/21 at 1:35 PM, the Health Facilities Inspector was not screened with a temperature check and a COVID-19 questionnaire, including COVID-19 symptoms, travel history, and exposure to the virus prior to entry to the facility. The Inspector asked the Caregiver if there was anything she needed to check before letting people into the facility. The Caregiver stated, "No, just spray shoes". (See TAG Y0050) -The Caregiver was not wearing a face mask. (See TAG Y0050.) -At 1:40 PM, two visitors entered the facility without a temperature check or COVID-19 screening questionnaire. (See TAG Y0050) -Signage were posted at the exterior of the front door related to use of hand sanitizer, wearing a mask, check temperature prior to entering, and COVID-19 symptoms. -There was a Temperature Screening Station sign posted above the electric wall mounted infrared thermometer. -There was a visitor sign in / out log with instructions: "Please check your temperature". -Personal Protective Equipment (PPE) supply included 2,700 gloves, 320 surgical face masks, five N95 masks, 100 poly disposable aprons, 12 face shields, and eight eye protection glasses. -There were eight pump bottles of hand sanitizer, two spray cans of hand sanitizer, and one hand sanitizer refill bottle. -Cleaner and disinfectant included Lysol wipes and Clorox ammonia-based spray cleaners. -	0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2787	A. BUILDING _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS CARE HOME	**5125 MEADOWS LILLY AVE, LAS VEGAS, NEVADA ,89108**

(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
	Tables and chairs in the living room, dining room, and backyard patio were spaced six feet apart for social distancing. -The Manager returned to the facility with a resident after the resident's doctor appointment. The Manager screened herself and the resident with a temperature check at the entryway, washed her hands and directed the resident to wash their hands. Interview with the caregiver and manager revealed: -The facility received an email on 10/01/20 with recommendations of COVID-19 infection control measures. -The Caregiver who answered the door reported she did not know how to screen persons entering the facility. (See TAG Y0050) -The Owner and the Manager verbalized the Caregiver should have screened the Inspector before allowing entry into the facility. Specifically, the Caregiver should have ensured the Inspector had the temperature taken and asked if the Inspector had any COVID-19 symptoms. (See TAG Y050) -The Owner and the Manager stated the Caregiver should have worn a face mask. All employees were trained in wearing PPE. (See TAG Y0050.) -The Manager reported the visiting policy allowed visitors if they passed COVID-19 screening checks and wore a mask. -The Owner indicated it was okay for visitors to walk into the facility without screening for COVID-19. (See TAG Y0050) -The Caregiver indicated doorknobs are cleaned three times a day with Clorox wipes and Lysol spray. -The Manager reported every resident has a temperature check once daily, in the morning, and are screened with a temperature check upon returning to the facility -should they need to go outside the facility for a doctor appointment, banking, or other errands. Employees get a temperature check daily prior to the start of shift. -The Owner reported she was medically cleared and fit tested for an N95 mask. -The Manager, the Owner, and two residents verbalized they all received the COVID-19 vaccine on 01/18/21. -The Manager indicated social distancing is adhered to during meals while both residents eat in the dining room. Two residents eat outside on the patio, two residents eat in front of the food trays in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2787	A. BUILDING _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS CARE HOME	**5125 MEADOWS LILLY AVE, LAS VEGAS, NEVADA ,89108**

(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
	living room, and two of the residents eat in their bedrooms. -The Manager verbalized in the event a resident developed COVID-19 symptoms or a positive test result, the resident would immediately be isolated in a private room with dedicated staff. The facility would notify the physician, the family member, and the State Office of Public Health Investigations and Epidemiology (OPHIE). Document Review: -The facility had an Infection Control and Prevention Plan. -N95 Medical Clearance and FIT testing for the Owner. 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:			
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 and interview, the facility failed to ensure infection control practices were practiced during the COVID-19 pandemic. Findings include: Facility staff failed to take the temperature or screen the health facilities inspector and essential visitors prior to entry to the facility. Facility staff did not wear a mask while providing care to residents. The facility received an email on 10/01/20 with recommendations of COVID-19 infection control measures. Severity: 2 Scope: 3	0050	1) Facility staff had another Covid-19 training the day after the Infection Control Survey 01/20/2021. 2)Administrator/ Owner will ensure the staff will follow Covid-19 Policy and Procedure. 3) Administrator/Owner will monitor for compliance. 4) Administrator/ Owner. 5) 02/02/2021 6) three documents attached.	02/02/2021