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
	2850	A. BUILDING _____ B. WING _____	12/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN CENTER, LLC 2	1895 PRISCILLA ST, LAS VEGAS, NEVADA ,89115

(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 in your facility on 12/27/17. This State Licensure survey was conducted by the authority of NRS 449.0307 Powers of the Division of Public and Behavioral Health. The facility is licensed for six Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and five 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 investigations, 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		

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0178 SS= F	449.209(5) - Health and Sanitation-Maintain Int/Ext - NAC 449.209 Health and sanitation. 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 the premises was clean and well maintained. Findings include: On 12/27/17 in the morning, the following were observed: - Liquid had leaked and covered the bottom of the inside of the refrigerator and inside the bottom left drawer of the refrigerator. A suppository was located in a locked box in the bottom left drawer and liquid had gotten inside the medication box. - The corners in the kitchen behind the medication cart had heavy dirt build-up. - The countertop in the kitchen had a film of heavy grease and dirt build-up. - Both shower curtains in the double occupancy room and the hallway bathroom had orange colored build-up at the bottom of the inside of the curtain. - The tub mat in the hallway bathroom had a black colored build-up on it. - The bathtub in the double occupancy room had a build-up in the bottom of the tub and the non-skid fish on the bottom of the tub had dirt build-up. - The blinds throughout the facility had a heavy dust build-up. On 12/27/17 in the morning, the Administrator acknowledged the findings and agreed it should have been cleaned. Severity: 2 Scope: 3	0178	A) - The caregivers immediately removed the liquid and cleaned the inside of the refrigerator during the survey and were witnessed by the surveyor. - All areas in the kitchen were cleaned. Heavy grease and dirt build up were removed as well. - All shower curtains were washed and tub mats were replaced. - The bath tub in the 2nd bathroom was cleaned and painted. - All the blinds throughout the facility were cleaned. B) The administrator will check on a regular basis to ensure that the premises are clean and well maintained. The administrator instructed all staff to do regular cleanings in all areas of the house and regular inspection of the facility will be done by the administrator to ensure a safe and clean environment.	01/06/2018

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0920 SS= F	449.2748(1-2) - Medication Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured. Findings include: On 12/27/17 at 9:30 AM, the medication cart located in the kitchen was unsecured and the gate to the kitchen was unlocked. On 12/27/17 at 9:30 AM, Caregiver #2 indicated she had just arrived and did not know why the medication cart was unlocked and should have been secured. Severity: 2 Scope 3	0920	A) The administrator called a meeting with all the staff after the survey and explained to them the risks and dangers of leaving the medication cart and kitchen gate unlocked. Caregiver#2 who was med tech on duty during the survey was given a warning notice for non-compliance. B) The administrator will check on a regular basis to make sure that the medication cart and gate to the kitchen are locked when left unattended. The administrator will issue a disciplinary action to the staff on duty for non-compliance. The administrator will be responsible for compliance.	12/28/2017

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0991 SS= F	449.2756(1)(b) - Alzheimer's Fac door alarm - NAC 449.2756 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 3 of 3 of the exit doors had installed alarms that operated when the exit door was opened. Findings include: On 12/27/17 at 9:30 AM, upon entering the facility the door alarm leading into the kitchen was not turned on. During the tour of the facility the back sliding glass door and the main entrance door alarms were turned off. Resident #4 had asked the caregivers several times to go outside and Caregiver #3 reported the resident enjoyed going outside. On 12/27/17 at 10:30 AM, the Administrator acknowledged the door alarms should have been on because it is a dementia facility. Severity: 2 Scope: 3	0991	A) The administrator conducted a training for all staff on how to operate the door alarms on all exit doors and reiterated to them the importance of keeping the door alarm "turned on" at all times. The alarm on the backsliding glass door and the kitchen door were replaced with new, easy to operate door alarms. The alarm is now kept "on" at all times. B) The administrator will ensure that all the doors that can be used to exit the facility have operational, audible alarms and that the alarms are kept "on" at all times. The administrator will check on a regular basis to ensure compliance.	01/03/2018