DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**06/21/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CREST HOME CARE	**4462 FARMCREST DRIVE, LAS VEGAS, NEVADA ,89121**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated in your facility on 05/19/21 and completed on 06/21/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 10 Residential Facility for Group beds for elderly or disabled persons, with an endorsement for persons with mental illnesses, Category II. The census at the time of the survey was five. The sample size was six. The facility received a grade of C. There was one complaint investigated. Complaint #NV00063898 with five allegations was substantiated. Allegation #1: Facility used restraints (bedrails) with a resident was substantiated. (See TAG 0557) Allegation #2: Facility failed to notify a responsible party for a resident who experienced an injury. (See TAG 0850) Allegation #3: Facility failed to notify a medical provider for a resident who experienced an injury. (See TAG 0850) The following allegations could not be substantiated: Allegation #4: The facility neglected a resident by leaving a resident in their underwear with a fan blowing on them could not be substantiated based on interview with the Resident who indicated they preferred to sleep and relax in their room this way and it was their choice to sleep in their room with the fan and no shirt and pants. Allegation: #5: Facility failed to treat residents with dignity and respect could not be substantiated based on interviews with residents who denied employees failed to treat them with dignity and respect and observations of caregivers providing care to the residents. The investigation into the allegations included: Observations of the facility environment, residents, and staff interaction with residents. Review of six resident files, three employee files, and medical records for two residents. Interviews with four residents,	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRIS MIRANDO Title: Administrator Date: 07/11/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	one resident's Power of Attorney, one Hospice Intake Coordinator, one Hospice Certified Nursing Assistant, one Hospice Registered Nurse, One Hospice Chief Operating Officer, two caregivers, and 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. Additional deficiencies not related to the complaint were identified during the complaint investigation survey. The following regulatory deficiencies were identified:			
0040 SS= F	Supervision of AGC - NRS 449.186 Supervision of residential facility for groups. A residential facility for groups must not be operated except under the supervision of an administrator of a residential facility for groups or a health services executive licensed pursuant to the provisions of chapter 654 of NRS. Inspector Comments: Based on document review, and interview the facility failed to ensure a residential facility for groups was operated under the supervision of an administrator of a residential facility for groups or a health services executive licensed pursuant to the provisions of chapter 654 of NRS. Findings include: On 05/13/21, the Board of Examiners for Long Term Care Administrators (BELCTA) confirmed the previous administrator requested to have their administrator licensed removed from the facility effective 05/01/21. On 05/19/21 in the morning, Employee #1 and the Owner confirmed the facility has not had a licensed administrator since 05/01/21. Severity: 2 Scope: 3	0040	New Administrator was appointed on 6/1/2021 by Owner. Owner will ensure that the home will not operate except under the supervision of an administrator of an RFFG. If any change of administrator, Owner will find another administrator within 10 days per regulation going forward.	06/01/2021

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0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure residents were not confined by using full bedrails for 1 of 5 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted to the facility on 04/28/21 with diagnoses including failure to thrive, absence of both cervix and uterus, malignant neoplasm of the brain, and essential hypertension and directions to provide palliative care. On 05/19/21 in the morning, R3 was observed in bed with full bedrails up. The resident appeared unable to speak and did not appear to realize they were being asked questions. The resident's bed was pushed up against the wall and the residents was not able to demonstrate lowering the bedrails on their own. On 05/19/21 in the morning, Employee #1 explained R3 is unable to sit up or reposition in bed without assistance and R3 could not raise or lower the bedrails on their own without assistance. The employee explained they were unaware it was considered a restraint to use full bedrails when a resident could not lower them independently. Severity: 2 Scope: 1 Complaint #NV00063898	0557	Resident #3 passed away on 5/20/2021. New Administrator conducted training on all current staff on 7/10/2021 on regulations regarding restraints and bedrails. Administrator or Designee will conduct training on regulations regarding restraints and bedrails as part of new hire training going forward. Only half rails will be allowed in the Home effective immediately and will only be used for assistive device by Resident.	07/10/2021

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0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on interview and record review, the facility failed to obtain a bed fast waiver/exemption for a resident (Resident # 3). Findings include: Resident #3 (R3) R3 was admitted to the facility on 04/28/21 with diagnoses including failure to thrive, absence of both cervix and uterus, malignant neoplasm of the brain, and essential hypertension and directions to provide palliative care. The resident file lacked documented evidence of a bed fast waiver/exemption for the resident. On 05/19/21 in the morning, R3 was observed lying in a hospital bed with full bed rails up. R3 did not respond to questions and was unable to rotate position or sit up in bed when requested. On 05/19/21 in the morning, a Certified Nursing Assistant (CNA) from R3's hospice agency was observed providing care to the resident. The CNA confirmed the R3 is unable to reposition in bed or sit up without assistance and is bedfast. On 05/19/21 in the morning, Employee #1 confirmed the R3 cannot sit up or reposition in bed without assistance. The Employee explained they were unaware a bedfast waiver/ exemption was required and confirmed the facility had not obtained the exemption for R3. Severity: 2 Scope: 1	0830	Resident #3 passed away on 5/20/2021. New Administrator conducted training of all current staff on the proper procedures to obtain Bedfast waivers on 7/10/2021 with the State. Any existing and/or future Residents requiring bedfast or other exemption waivers will be submitted by Administrator to the Bureau going forward. All future staff will be trained on these requirements going forward by Administrator or Designee.	07/10/2021
0850 SS= J	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) 1. If a resident of a residential	0850	New Administrator conducted a training of current staff on appropriate procedures for Incident Reporting and whom to notify regarding Incidents. Training was completed on 7/11/2021. All future staff will be trained as part of new hire process on	07/11/2021

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	facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure a resident's physician, hospice agency and family member were notified a resident sustained an injury of unknown origin to the head (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 01/12/21, with diagnoses including dementia and chronic combined systolic and diastolic heart failure. Review of R1's file revealed an incident report dated 04/28/21 which documented R1 was found in their bed at approximately 8:00 AM with a black mark on their forehead. The incident report lacked documented evidence R1's family member, physician, and hospice agency were notified of the resident's injury. On 06/08/21 in the afternoon, R1's Power of Attorney (POA) and family member indicated the facility did not notify the POA the resident had sustained an unwitnessed injury on 04/28/21. The POA reports R1's dialysis company came to the facility around noon on 04/28/21 to pick up R1 for an appointment and observed a bump on R1's head. The dialysis company staff called the POA around 12:30 PM on 04/28/21 to notify the POA of the observation of injury to R1. The POA arrived at the facility on 04/28/21 at approximately 5:00 PM, observed the bump on R1's head, and called an ambulance to transport R1 to a local emergency room. R1's POA explained R1's primary care physician was provided through Hospice Agency #1. A review of hospital records indicate R1 was admitted		appropriate protocols regarding any Incident reports, falls (witnessed or unwitnessed) and proper notification procedures.	

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	to the emergency room on 4/28/21 with the diagnosis of a left frontal hematoma. Physician notes indicated the injury occurred due to a mechanical fall resulting in intracerebral hemorrhage and subdural hematoma. A head Computed Tomography (CT) scan revealed an acute 3-centimeter (cm) acute frontal hemorrhage with additional left sided hemorrhages, intraventricular hemorrhage and a 3 to 4 (millimeter)mm left subdural hematoma. The neurological prognosis indicated the "Prognosis is grave with recent fall and frontal lobe hemorrhage with intraventricular and subdural expansion. Patient poorly responsive, with palliative performance score of 10%." Hospice records indicate the resident was discharged from the hospital to a Hospice Agency #2 on 4/30/21. Hospice #2 records documented the resident passed away on 4/30/21. On 05/19/21 in the morning, Employee #1 confirmed they had observed a black mark on R1's forehead and had written the incident report regarding the unwitnessed injury on 04/28/21. Employee#1 confirmed they had not notified the POA of the unwitnessed injury to R1. Employee #1 was unable to provide documented evidence R1's physician and hospice agency were notified of the injury. On 06/21/21 in the morning, the nurse assigned to R1 from Hospice Agency #1 explained they did not recall receiving a report from the facility regarding a possible fall on 04/28/21. The nurse reported if Hospice Agency #1 had received a call regarding an injury to R1, a representative from Hospice Agency #1 would have arrived at the facility to conduct an assessment within one hour of receiving a report of injury. On 06/21/21 in the morning, an interview with the Intake Coordinator of Hospice Agency #1 revealed there was no record the facility contacted Hospice Agency #1 to report a fall on 04/28/21. The Intake Coordinator explained if Hospice Agency #1 had received a report of a fall or an injury it would be logged in			

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	R1's file and there were no notes indicating Hospice Agency #1 received a report from the facility of a possible fall of R1 on 4/28/21. On 06/21/21 in the morning, interview with the Chief Operating Officer (COO) of Hospice Agency #1 who reported a review of the call logs indicate R1's family called Hospice Agency #1 on 04/28/21 at 7:07 PM to notify them the family was seeking treatment at the hospital for R1 due to a reported fall. The COO explained if Hospice Agency #1 received a report from the facility of a possible fall or unknown injury a representative would have been dispatched to assess the resident within one hour. The COO reported there is no record the facility contacted Hospice Agency #1 or that a nurse or any other representative went to the facility to assess a resident for a possible fall on 04/28/21. Severity: 4 Scope: 1 Complaint #NV00063898			
0960 SS= D	Alzheimer’s Care Application for Endorsement - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer ' s disease. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on observation, interview, and record review, the facility admitted and retained two residents diagnosed with Alzheimer's disease or related dementia (Residents #1 and #2). Findings include: The facility is licensed as a residential facility for groups to provide care for ten residents, with endorsements for elderly or disabled	0960	Resident #1 was discharged from the Home on 4/28/2021 and Resident #2 was discharged from the Home on 6/24/2021. Training of staff by Administrator regarding acceptable Residents based on current licensure of the Home was conducted and completed by 7/11/2021. No Residents with Alzheimer's or Dementia will be admitted going forward unless the Home has received a completed Alzheimer's Endorsement and staff have the appropriate trainings in their employee files upon new hire and annually.	07/10/2021

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	persons and/or persons with mental illnesses. The facility did not have an endorsement to provide care for persons with Alzheimer's disease or related dementia. Resident #1 (R1) R1 was admitted on 01/12/21, with diagnoses including dementia and chronic combined systolic and diastolic heart failure. The file lacked documented evidence of a Physician Placement Determination form. Resident #2 (R2) R2 was admitted to the facility on 02/05/21 with a diagnosis of unspecified dementia with behavioral disturbances. A physicians assessment dated 10/29/20 indicated the R2 is to be closely monitored. The file lacked document evidence of a Physician Placement Determination form. On 05/19/21 at 8:52 AM, the R2 was observed unlocking two chain locks and a deadbolt on the front door. R2 was observed walking out the front door without any caregivers present. Caregivers were called for assistance by the Health Facilities Inspector and there was no response by caregivers until the third call for assistance. R2 was observed walking in the middle of the street where a caregiver caught up with the resident and redirected them back into the facility. At 09:51 AM R2 attempted to leave the facility again but stopped when they could not remove the chain lock to the door. R2 made the following statements which suggested the resident is exit seeking and exhibited confusion: -"I'm going to get out there and go to the bank." -"I'm going to get back out there and play ping pong." -"I got to go get my car." -"If I open the door, will you take me?" On 05/19/21 in the morning, Employee #1 explained they must supervise R2 constantly or the resident will interfere with other residents' care. R2 would go into the residents' rooms and disturb the residents or interrupt caregivers from providing care to the other residents. On 05/19/21 in the morning, the Owner acknowledged the facility did not have an endorsement for Alzheimer's or related dementia. Severity: 2 Scope: 2 This is a			

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	repeat deficiency from the 07/17/20 annual inspection.			