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 _____	**02/15/2022**

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

(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, infection control survey and complaint investigation conducted at your facility on 02/15/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, with an endorsement for mental illness, Category II residents. The census at the time of the survey was seven. Seven resident files and four employee files were reviewed. The facility received a grade of A. One complaint was investigated. Complaint# NV00065708 with three allegations was unsubstantiated. Allegation #1-The facility failed to administer medications as prescribed and obtain medication refills was unsubstantiated based on interviews with three facility Caregivers who reported all physician orders for medications were filled and refilled in a timely manner and review of all residents' Medication Administration Records (MARs) for January and February, 2022 against the medication administered, available and onsite which did not reveal any missed medication doses. Allegation #2-The facility failed to communicate with a resident's medical providers and follow a plan of care was unsubstantiated based on interviews with three facility Caregivers who reported that it is facility policy to contact a resident's medical provider and any family/Legal Guardian/Power of Attorney in the event of a change in condition or incident involving any facility resident and review of facility assessments which determined the level of assistance that each resident required due to their medical conditions. Allegation #3-The facility failed to obtain appropriate medical care for a resident upon change of condition or behaviors was unsubstantiated as a result of interviews with three facility Caregivers	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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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	who reported that it is facility policy to contact a resident's medical provider and any family/Legal Guardian/Power of Attorney in the event of a change in condition and was confirmed as being done for the resident of concern, along with verification of the resident visiting their Primary Care Provider in the afternoon of 02/09/22 and obtaining new medication prescriptions. The investigation into the allegations included: Observations of communications between facility Caregivers, residents and Caregivers and between residents throughout the day. Interviews with three Caregivers and two residents. File reviews of seven facility residents. Document reviews of resident MARs, physician assessments and facility assessments. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of non-discrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.			