STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2973	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR CARE	5408 TOPAZ STREET, LAS VEGAS, NEVADA ,89120

(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 State Licensure Annual Grading survey conducted at your facility on 07/01/21, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility was licensed for ten Residential Facility for Group beds with endorsements for elderly / disabled persons, Alzheimer's or related dementia, and mental illness, Category II residents. The census at the time of the survey was ten. Ten resident records and five employee records were reviewed. The facility received a grade of B. 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 regulatory deficiencies were identified:	0000		
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, interview, and document review, the facility failed to ensure an Infection Control and Prevention Policy was implemented and maintained in response to the COVID-19 pandemic. Findings include: 1) Screening: On 07/01/21 at 10:25 AM, the Health Facilities Inspector was not screened for symptoms upon entry to the facility. At 10:35 AM, the Administrator arrived at the facility and did not undergo temperature checks or symptoms screening before entering the facility. 2) Personal Protective Equipment (PPE): On 07/01/21 from 10:25 AM through 10:45 AM, a Caregiver was not	0050	1.How you will correct the specific finding stated in the Statement of Deficiencies? In order to become compliant with the regulations pertaining to infection control, the administrator post a placard on the entrance door stating temperature check and visitors experiencing shortness of breath, cough and fever are not allowed to enter in the facility. Mask required signage are posted in all areas of the facility. Additionally, visitors and caregivers are ask to wear mask at all times, fill up and answers Covid 19 screening questionaire prior to entering the facility. Visitors are allowed to visit and practice 6 feet social distancing. All caregivers are instructed to have temperature checks, covid screening and wear mask at all times. 2. What measure or systematic change will be put into place to ensure the deficient practice does not recur? The administrator takes responsibility to ensure that facility employees and visitors are wearing mask and practice social distancing at all times. The inspection will be done each day to ensure the facility is in	07/05/2021

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	wearing a face mask. 3) Visiting Policy: The Administrator verbalized it was the facility's policy and practice to not allow any visitors to enter the facility unless they have documented vaccination records for COVID-19. The Administrator indicated this policy was not outlined in the facility's Infection Control and Prevention Plan. This practice did not provide for reasonable visitation for hospice residents and for visitors who were not vaccinated to visit with screening, masks, and social distancing in an open air environment, such as the back yard. The Administrator verified it was the expectation that all employees should wear face masks. Screening should be completed with a temperature check and symptoms questioning prior to allowing visitors and employees to enter the facility. Severity: 2 Scope: 3		compliance with the regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will conduct inspection each day to ensure facility is in compliance with regulations pertaining to infection control. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator of the facility is responsible. 5. The date the corrective action will be completed. Corrective action was completed on July 5, 2021. 6. You must attach all supporting documents into the system. ATTACHMENT #1 (ONE) 7. How you will identify and correct other areas having the the potential to be affected by the same deficient practice? All the residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	
0878 SS= E	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a	0878	1. How you will correct the specific findings stated in the Statement of Deficiencies? RESIDENT #1: In order to be compliant with regulation, the use of syringe for feeding Resident #1 was used. Every meals syringe is used to feed her. RESIDENT#4: In order to be compliant with regulations, Resident #4 MAR was corrected on day of the survey. Resident #4 MAR stated Acetaminophen 325 mg 1 tablet every six hours as needed for pain. Resident # admitted on 6/15/20 MAR was corrected on the day of the survey. Levothyroxin 112 mcg is given at 6 in the morning and Ferrous Sulfate 325 mg is given at 10 in the morning. RESIDENT #8:	07/04/2021

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	medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure physician's instructions were followed for 3 of 10 sampled residents (Resident #1, #4, and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 03/07/16 with diagnoses including failure to thrive, end stage Alzheimer's dementia, and a history of dysphagia. R1 was on hospice services effective 03/28/19. The Physician Extender (Nurse Practitioner) physical examination notes dated 12/29/20 documented R1 required 1:1 feeding with pureed diet, all feedings require syringe. The Physician re-certification of 05/12/21 documented R1 required one on one feeding. (R1) had begun to refuse feedings by keeping mouth closed at mealtimes...R1 was fed one on one. R1 pockets food, even with a pureed diet, and experiences postprandial dysphasia. On 07/01/21 R1 was observed being fed with a spoon by a Caregiver. R1 ate very slowly and had mild coughing episodes. The Caregiver verbalized she always fed R1 with a spoon		In order to be compliant with regulations, Resident #8 MAR was corrected on the day of the survey. Resident #8 received Albuterol 0.083% treatment three times a day routinely. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator takes responsibility to ensure medications are given following the orders of the doctor/ nurse practitioner. In addition, administrator will check notes regularly of the doctor/nurse practitioner's order to ensure that orders are followed. This will be done daily so that facility will be in compliance with regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator of Joyful Senior Care will check notes and orders of the doctors/ nurse practitioner daily so that requirements are followed in timely fashion. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective action will be be completed. The corrective action was completed on July 4, 2021. 6.You must attach all supporting documents into the system. ATTACHMENT #2 (TWO) 7. How will you identify and correct other areas having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	

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	and was not aware of the physician's instructions to feed R1 with a syringe. The Administrator indicated R1 was appropriately fed with a spoon and did not need to be fed with a syringe. The Administrator reported she was not aware of the Nurse Practitioner's instructions to feed R1 with a syringe. The Administrator verified there was no written clarification or new order for R1 to be fed with a spoon. Resident #4 (R4) R4 was admitted to the facility on 04/03/21 with diagnoses including acute kidney injury, metabolic encephalopathy, and Alzheimer's disease. -Acetaminophen: The physician's order for Acetaminophen, 325 milligrams (mg), 1 tablet every six hours as needed for pain was dated 05/11/21. The Medication Administration Record (MAR) for the months of June and July of 2021 had documented instruction to administer 2 tablets every six hours as needed for pain. The Administrator verified the correct order of 1 tablet every six hours as needed should have been written on the MAR's, and stated it was a clerical mistake. -Levothyroxine and Ferrous Sulfate: The two medications were filled on 06/03/21, with physician's orders as follows: Levothyroxine, one tablet by mouth before breakfast for thyroid replacement; Separate at least four hours from iron pill (Ferrous Sulfate). The MAR's for the months of June and July of 2021 documented the Levothyroxine was administered daily at 8:00 AM. The MAR's documented the Ferrous Sulfate, 325 mg, one tablet twice daily, was administered at 8:00 AM and at 8:00 PM for the months of June and July of 2021. The Administrator verbalized the Ferrous Sulfate should have been administered four hours after the Levothyroxine per the physician's orders. Resident #8 (R8) R8 was admitted to the facility on 04/22/14 and was receiving hospice care with a diagnosis of end stage Alzheimer's dementia. The MAR's for June and July of 2021 documented the SVN (small volume nebulizer) was to be administered 1 vial every six hours as needed for coughing and wheezing. The Nurse Practitioner's physical encounter dated 02/02/21 documented R8 has had increased phlegm in back of throat, which			

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	will often choke patient along with constant drooling. This patient requires SVN treatments three times a day for airway. The Administrator verified the SVN treatments were not administered three times daily on a routine basis for the months of June and July of 2021, and verbalized she was not aware of the Nurse Practitioner's instructions to administer the SVN treatments three times a day routinely. Severity: 2 Scope: 2			

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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 interview and record review, the facility failed to ensure one of ten residents had tuberculin testing (Resident #7). Findings include: Resident #7 (R7) R7 was admitted to the facility on 05/17/21 with diagnoses including congestive heart failure and chronic obstructive pulmonary disease. There was no documentation of initial 2-step tuberculin testing. The only documented tuberculin test was dated 01/19/21, with no read date. Severity: 2 Scope: 1	0936	1. How you will correct the specific findings stated in the Statement of Deficiencies. In order to become compliant with regulation pertaining to TB test, Resident 7 received 2 step TB test on July 2, 2021 and July 15, 2021. All test are negative. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator will maintained resident files and audit and update the files constantly so that all requirements will be met and carried on in timely manner. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will maintained resident files and audit and update it constantly so that requirements will be met and carried on at all times. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator of the facility is responsible. 5. The date the corrective action will be completed. Corrective action was completed on July 15, 2021. 6. You must attach all supporting documents into the system. ATTACHMENTS #3 (THREE) 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All the residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	07/13/2021

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 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 operational alarms were provided on two of three exit doors. Findings include: On 07/01/21, the door to the back yard and the door from Room #5 to the side yard were not equipped with audible alarms. The Caregiver indicated the alarm was usually on, but the employees had turned off the alarm on the door to the back yard because it was so loud. The Administrator acknowledged audible alarms should have been activated upon opening the doors to the outside. Severity: 2 Scope: 3	0991	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation pertaining to door alarms, an operational door alarm was installed on Resident #5 room exit door. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator of Joyful Senior Care takes responsibility to ensure all door alarms are operational at all times so that facility is in compliance with regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will monitor door alarms daily to ensure that facility will be in compliance with regulation. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator of Joyful Senior Care is responsible. 5. The date of corrective action will be completed. The corrective action was completed on July 8, 2021. 6. You must attach all supporting documents into the system. ATTACHMENT #4 (FOUR) 7. How you will identify and correct other areas having the potential to be affected by the same deficient practice? All the residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	07/08/2021
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to	0999	1. How will you correct the specific findings stated in the Statement of Deficiencies? In order to be compliant with regulation pertaining to toxic substance, the administrator installed six motion sensor hand sanitizer dispensers in the entrance door, living room, each bathrooms and	07/06/2021

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	persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 07/01/21, the following toxic substances were accessible to residents: -Seven bottles of alcohol-based hand sanitizer were observed in rooms throughout the facility (entryway, Living Room, Dining Room, kitchen, two bathrooms, and resident room). -OdoBan spray bottles were stored in the kitchen. the Living Room, and the bathroom in Room #5. The Administrator acknowledged the hand sanitizer bottles and spray cleaners were placed within access of residents. Severity: 2 Scope: 3		kitchen area. All toxic sprays, disinfectants and sanitizer pumps are kept in the bathrooms and kitchen cabinets are locked. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator takes responsibility to ensure the motion sensor hand sanitizer is operable to use and cabinets are locked at all times.It will be checked daily so that facility will be in compliance with the regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator of Joyful Senior Care takes responsibility to ensure that cabinets are locked and motion sensor hand sanitizer is working at all times so that all requirements are met and carried on at all times. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator of Joyful Senior Care is responsible. 5. The date of corrective action will be completed. The corrective action was completed July 6, 2021. 6. You must attach all supporting documents into the system. ATTACHMENT #5 (FIVE) 7.How you will identify and correct other areas having potential to be affected by the deficient practice? All residents having the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	