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 _____	**09/23/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGE AT PARADISE VALLEY ASSISTED LIVING	**2205 EAST HARMON AVE, LAS VEGAS, NEVADA ,89119**

(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 a State Licensure Complaint Investigation initiated at your facility on 09/01/21 and completed on 09/23/21, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The facility is licensed for 91 Residential Facility for Group beds for elderly or disabled persons, with endorsements for Assisted Living Services, persons with mental illness, and persons with chronic illness, Category II. The census at the time of the survey was 58. The sample included one resident. The facility received a grade of A. Complaint #NV00064731 with two allegations was not substantiated: Allegation #1: A resident overdosed on pain medications and the facility did not contact emergency services for transfer to the hospital for treatment was not substantiated based on lack of evidence an incident involving pain medication overdose occurred. Review of acute care facility medical records and interviews with the resident of concern, the Resident Care Coordinator, the Resident Care Director, and the Nurse Practitioner revealed lack of evidence of a medication overdose. Allegation #2: A resident's family member did not return the resident to the facility after a shopping trip on 08/21/21, the resident missed medication dosages, and the facility did not contact law enforcement was not substantiated based on the resident was taken to the hospital by the resident's family member for medical care on 08/21/21. The facility provided documentation multiple attempts were made to locate the resident and contact the family member. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CATHERINE HELTON Title: Executive Director Date: 12/07/2021

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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	under applicable federal, state, or local laws. Other deficiencies unrelated to the complaint allegations were identified during the course of the complaint investigation survey. See Tag 0876 The following regulatory deficiencies were identified:			
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on interview, record review, and document review, the facility failed to provide a written agreement to assist in the administration of medications for one resident (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/31/21 with diagnoses including chronic obstructive pulmonary disease, hypertension, opioid dependence, and hip pain. There was an unsigned and undated Ultimate User Agreement in R1's file. The Ultimate User Agreement indicated the resident agreed to have the facility provide assistance with administration of medications as well as agreed the resident would take full responsibility for medications. On 09/23/21, the Resident Care Coordinator verified the Medication Administration Records had initials of the Medication Technicians for medications which were actually self-administered by R1 and stored in R1's room at bedside. The Resident Care Coordinator reported R1 had taken back control over the	0876	"The Bridge at Paradise Valley utilizes the Ultimate User Agreementas well as PCC Program for documenting and implementing our Med ManagementProgram for residents. On Sept. 9th, 2021 we received a doctor's note fromAwana Ring stating that we were to discontinue Med Management for Awana. Wethen discontinued Med Management for her filling out the Ultimate UserAgreement, but Awana refused to sign it. Per Awana Ring's doctor's orders wemoved forward with discontinuing service. Preventative Measures: Before and after Pam Ross's (Nevada Health Dept) visit in September of2021, we educated staff on the importance of documentation/communication, aswell as the importance of	12/07/2021

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	medications off and on, and verbalized she did not know what dates the medications were actually in the facility's custody and administered by staff. The Resident Care Coordinator acknowledged the Ultimate User Agreement was unsigned, undated, and unclear as to whether the resident agreed to facility assistance with medications or retained sole responsibility to self-administer medications. Upon admission, each resident and a facility representative are supposed to sign admission paperwork, including the Ultimate User Agreement designating medication management and over site. Severity: 2 Scope: 1		completing necessary documents like the Ultimate UserAgreement entirely and completely. Any staff member who fails to comply withthese instructions will be written up and could lead to termination ofemployment."	