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 _____	**11/09/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNIFIED CARE MANOR	**2915 EL CAMINO RD, LAS VEGAS, NEVADA ,89146**

(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 complaint investigation at your facility on 11/09/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was seven. The sample size was six. There was one complaint investigated. Complaint #NV00062470 with four allegations was unsubstantiated. Allegation #1: Residents had bruises on forearms was unsubstantiated based on observations of six residents' forearms, lower legs and face; Interviews conducted with three residents and staff members. Allegation #2: Lack of supervision for monitoring residents; half of employees quit was unsubstantiated based on interviews with two residents and staff members. Observation of two Caregivers on shift at the beginning of the survey. A third Caregiver arrived at 11:00 AM during lunch. Allegation #3: Residents had difficulty eating without dentures; food preference not honored was unsubstantiated based on interviews with residents and staff members; observation of lunch served. Two residents in the facility wore dentures. Six residents were observed eating lunch served without difficulty. Allegation #4: Residents did not have access to food for days was unsubstantiated based on interviews conducted with three residents, two staff members and one Director of Nursing from a Home Health Agency. Observation of three refrigerators stocked with perishable foods (fruits, bread, meats, eggs) and three cabinets stocked with non-perishables. The investigation into the allegations included. Observations of care provided to residents, the facility environment, lunch (Shredded chicken, mashed potatoes, mix vegetables and cake). Interviews with three residents, two Caregivers, one Administrator and Director of Nursing from Home Health Agency.	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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	Review of six resident files and two employee files. 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. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.			