

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2021
NAME OF PROVIDER OR SUPPLIER PRIME CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4920 RONAN DRIVE, LAS VEGAS, NEVADA ,89110		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure and infection control survey conducted at your facility on 10/27/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for seven Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, Category I residents. The census at the time of the survey was seven residents. Seven resident files and two employee files were reviewed. The facility received a grade of A. 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 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:			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: JOSIFINA ADAMS Title: administrator
REPRESENTATIVE'S SIGNATURE

Date: 11/07/2021

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NAME OF PROVIDER OR SUPPLIER PRIME CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4920 RONAN DRIVE, LAS VEGAS, NEVADA ,89110		
(X4) ID PREFIX TAG 1011 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 1011	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 11/07/202 1
	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. Inspector Comments: Based on record review and interview, the facility failed to ensure eight hours of mental illness training was completed within 60 days of hire for 1 of 2 employees (Employee #1 - hired 08/05/16). The Administrator acknowledged the training was missing and was unable to provide documented evidence the training was completed. Severity: 2 Scope: 1		Employee number 1 had a mental illness training on 11/02/21. The certificate has been sent. Prime Care Facility has created a check list for employees. This check list was created to help staff keep track of trainings, certificates, and other requirements for employment.	