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 _____	**10/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA HILL MANOR	**5544 SURREY STREET, 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 an annual grading and infection control State Licensure survey and complaint investigation completed in your facility on 10/18/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 5. Five resident files, one discharge resident file, and five employee files were reviewed. The facility received a grade of A. One complaint was investigated. Complaint #64770 with two allegations was substantiated. Allegation #1: An employee was diagnosed with COVID-19 and the residents of the facility were not tested for COVID-19. (See TAG 0050) Allegation #2: A resident had two lesions on their hand and face was substantiated without deficiencies based on review of dermatologist records indicating a resident had been treated for lesions on the arms and face and received instruction on how to treat lesions in the future. Record review did not show evidence the resident had complaints after treatment was provided for the lesions. Interview with the Owner who explained a resident had received treatment for lesions on their face and hands and explained the resident had not had complaints after receiving treatment. The investigation into the allegations included: Observations of residents in the facility who did not appear to have lesions on their face or hands. Record review of resident files, and resident treatment records. Interviews with one resident, and the Owner. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of nondiscrimination policy; posting of nondiscrimination statement and	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CRISANTA PASSION Title: ADMINISTRATOR Date: 11/04/2021

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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	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. The following regulatory deficiencies were identified:			

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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 document review and interview, the facility failed to implement safe infection control practices for the protection of residents in response to the COVID-19 Pandemic. Findings include: A review of the facility policy titled COVID-19 Protocol indicated if a caregiver had positive signs and symptoms of COVID-19, the caregiver was sent home and tested. If the employee received a positive COVID-19 test, all employees and residents were tested. On 10/18/21 in the morning, Employee #4 (E4) acknowledged it was the facility's policy to test all employees and residents if an employee or resident received a positive COVID-19 test result. E4 confirmed the week of 07/26/21, E4 had signs and symptoms related to COVID-19 and took a COVID-19 test. The results were positive. E4 acknowledged the facility had not tested the residents or employees for COVID-19 after E4 received a positive COVID-19 test result, per the facility policy. Severity: 2 Scope: 3 This is a repeat deficiency from the 11/19/20 focused infection control survey. Complaint #64770	0050	1 a)An inservice regarding COVID protocol was conducted on 11/23/21. It was reiterated that testing has to be done for all employees and caregivers when somebody tests positive in the facility regardless the absence of signs and symptoms. It was also emphasized that administrator must be notified immediately as soon as a case occurs so administrator can help direct and assure that follow up procedures are executed properly and in a timely manner. b) Administrator will monitor for compliance. c)11/23/21	11/23/2021

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0994 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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure a rake in the backyard was secure. The rake was observed unsecured behind the shed in the backyard. The Administrator acknowledged the rake was not secured. Severity: 2 Scope: 3	0994	2a)Rake was placed inside the locked storage when pointed out by inspector (11/18/21). Administrator told employees that whoever uses the items that are considered dangerous is responsible for securing it.(11/23/21) b)Administrator will check for unsecured dangerous items when visiting the facility. c)11/18/21	11/18/2021