

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3730	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER IN TOUCH RESIDENTIAL CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7457 WALNUT CREEK DRIVE, LAS VEGAS, NEVADA ,89147		
(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 survey at your facility on 10/16/18, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for eight Residential Facility for Group beds for persons with mental illnesses and/or persons with chronic illnesses, Category I residents with seven low income beds. The census at the time of the survey was eight. Eight resident files were reviewed and two employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Health Division 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 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: TERESITA ENRIQUEZ Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 11/20/2018

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(X4) ID PREFIX TAG 1021 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 449.2766(2)(3)(4) - Chronic Illness Training - NAC 449.2766 Residential facility which offers or provides care for persons with chronic illnesses and debilitating diseases: Application for endorsement; training for employees. 2. Within 60 days after being employed by a residential facility for persons with chronic illnesses, an employee of the facility shall obtain at least 4 hours of in-service training relating to the care provided to such persons and in the actions necessary to control infections. 3. Evidence of training received pursuant to subsection 2 must be included in the employee's personnel file. 4. As used in this section, "residential facility for persons with chronic illnesses" means a residential facility that provides care and protective supervision for persons with chronic illnesses or progressively debilitating diseases, including, without limitation, acquired immunodeficiency syndrome and cancer. Inspector Comments: Based on record review and interview, the facility had a chronic illness endorsement and failed to ensure 1 of 2 employees received at least 4 hours of training for residents with chronic illnesses within 60 days of hire (Employee #1). Findings include: On 10/16/18 at 10:15 AM, the Caregiver's file lacked documented evidence four hours of chronic illness training was completed. The Administrator was unable to provide documented evidence and confined the Caregiver should have had the training since the facility was endorsed for chronic illness. Severity: 2 Scope: 1	ID PREFIX TAG 1021	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator immediately scheduled for employee to take the Chronic Illness class. B. The Administrator shall continue to monitor and check the Employee Files to ensure that all required training are current and compliance. C. Accomplished 10-21-2018	(X5) COMPLETION DATE 10/21/2018