Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3847	A. BUILDING _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS GROUP HOME	**261 E ELDORADO LANE, LAS VEGAS, NEVADA ,89123**

(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 annual survey initiated at your facility on 12/21/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for persons with mental illness and/or persons with chronic illness, three Category I and seven Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and four employee files were reviewed. The facility received a grade of B. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of nondiscrimination 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 investigation, 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:	0000		

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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 interview and employee record review, the facility failed to ensure infection control practices were implemented and maintained in response to the COVID-19 pandemic. Findings include: On 12/21/21 in the morning, Employee #1 (E1) opened the door to greet the surveyors and was not wearing a mask. E1 was observed on two additional occasions the morning of 12/21/21 not wearing a mask over their mouth and nose. A review of the facility's inventory of personal protective equipment (PPE) revealed the facility did not have a stock of N95 masks. A review of the facility's infection control policy indicated the facility staff should wear surgical masks while inside the facility and the facility should have a stock of N95 masks in case of an outbreak of COVID-19. On 12/21/21 in the morning, during a facility tour, E1 was asked if E1 usually wore a mask. E1 replied E1 was supposed to wear a mask, but had not done so on 12/21/21. E1 acknowledged E1 should have been wearing the mask covering their mouth and nose. Severity: 2 Scope: 3 This is a repeat deficiency from the 12/09/2020 Infection Control survey.	0050	1) In order to correct the specific findings stated in the SOD all employees are educated on proper wearing of mask, covering both mouth and nose. All employees are mandated to wear a mask properly at all times inside the group home. An N95 mask is in stock at the group home in case of covid outbreak. 2) In order to prevent the deficient practice to recur signs will be posted to wear a mask at all times and N95 mask inventory will be done daily. 3) The corrective action will be monitored by weekly staff meetings and daily inventory of all the supplies of PPE, N95 mask. 4) The administrator will be responsible for ensuring the POC is implemented. 5) The corrective action have been completed 12/23/2021.	12/23/2021

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure 1 of 4 employees met the background check requirements of Nevada Revised Statute (NRS) 449.124 (Employee #2). Findings include: Employee #2 (E2) E2 was hired as a Caregiver on 05/21/21. There was no documented evidence E2 had completed a background check. On 12/21/21, the Administrator and E2 acknowledged E2 had not completed a background check per the requirement. Severity: 2 Scope: 1	0104	1) In order to correct the specific finding stated in the SOD E2 had completed a background check per the requirement. 2) In order to prevent the deficient practice to recur a background check per the requirement will be implemented. 3) To monitor the the deficient practice will not recur there will be completed background check list. 4) Administrator will be responsible for ensuring the POC is implemented. 5) The corrective action was completed 12/22/2021.	12/22/2021
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the interior and exterior of the facility were well maintained and free of obstructions. Findings include: Exterior: On 12/21/21 at 9:45 AM, the back yard patio had the following tools and miscellaneous items observed: Five wheelchairs, a tile saw, and various other items. The back yard had a large stack of used clay roof tiles stacked along the southeast wall of the property. In addition, the southeast wall at the front of the home was leaning away from the property and a crack extended from the top of the wall to the bottom, creating a separation. Several cinder blocks on top of the wall were not secured, were loose and created a potential safety hazard. There were multiple piles of debris throughout the yard, including, discarded mirrors, construction debris, garbage, and a large rock pile. The miscellaneous debris was	0178	1) In order to correct the specific findings stated in the SOD the the trash and debris on the back patio and in the rear yard will be removed. The cinder block wall will be fix by digging both sides of the block wall footing as necessary. Demo 12x6 block wall to replace/repair cracked footing due to tree roots. Remove existing tree causing damage. Break out concrete footing where cracked and replace rear as needed. Pour new footing as needed and install 9 courses of cinder block to match existing. All the flooring on the interior will be fix, missing transition pieces will be placed and holes on wall in the laundry room will be patch. 2) To prevent the deficient practice to recur all repairs and clean up must be done in timely manner for everyone's safety. 3) In order to monitor we will discuss any necessary repairs, clean up in our weekly staff meetings. 4) The administrator is responsible for ensuring the POC is implemented. 5) Patio and debris in the back yard have been removed on 1/3/2022. All repairs will be done by Feb 15, 2022.	02/15/2022

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	contained to the edge of the property next to the cinder block fence. On 12/21/21 in the morning, the Administrator and Employee #1 (E1) acknowledged the trash and debris on the back patio and in the rear yard. The Administrator indicated they were not aware the cinder block wall had a crack in it and had loose bricks. Interior: On 12/21/21 at 8:30 AM, the flooring on the interior of the residence was cracked and peeling throughout the common areas and kitchen. The thresholds leading to the resident rooms were missing transition pieces between the main hallway floor and the bedroom floors. The lack of transition pieces created a gap between the hallway floor and the resident floor, creating a potential tripping hazard. In addition, several pieces of laminate flooring were missing in the kitchen area around the cabinets and dishwasher area preventing the area to be properly cleaned and sanitized. On 12/21/21 at 8:30 AM, a hole was observed in the foundation of the laundry room. There were also holes in the walls exposing plumbing pipes. On 12/21/21 in the morning, E1 and the Administrator acknowledged the cracks in the floor, the missing transition pieces, the missing laminate floor pieces, the hole in the foundation, and the holes in the wall of the laundry room. Severity: 2 Scope: 3			
0870 SS= F	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in	0870	1) In order to correct the specific findings stated in the SOD the review of medications for Residents #1,#2,#3,#4, #6,#7, #8,#9,#10 have been filed in their charts. 2) In order to prevent the deficient practice to recur the residents' chart will be checked to assure that all residents' medications are reviewed every 6 months. 3) In order to monitor that deficient practice does not recur chart review will be done weekly. 4) The administrator is responsible for ensuring the POC is implemented. 5) The corrective action was completed 12/22/2021.	12/22/2021

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	the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a review of medications was completed every six months for 9 of 10 residents (Residents #1, #2, #3, #4, #6, #7, #8, #9 and #10). On 12/21/21 in the morning, resident file reviews revealed the following: Resident #1 (R1) was admitted to the facility on 01/08/18. R1's file lacked documented evidence of a medication review every six months. Resident #2 (R2) was admitted to the facility on 04/15/21. R2's file lacked documented evidence of a medication review within six months of admission. Resident #3 (R3) was admitted to the facility on 10/16/19. R3's file lacked documented evidence of a medication review every six months. Resident #4 (R4) was admitted to the facility on 04/07/18. R4's file lacked documented evidence of a medication review every six months. Resident #6 (R6) was admitted to the facility on 01/12/20. R6's file lacked documented evidence of a medication review every six months. Resident #7 (R7) was admitted to the facility on 01/27/20. R7's file lacked documented evidence of a medication review every six months. Resident #8 (R8) was admitted to the facility on 02/09/21. R8's file lacked documented evidence of a medication review every six months. Resident #9 (R9) was admitted to the facility on 10/16/19. R9's file lacked documented evidence of a medication review every six months. Resident #10 (R10) was admitted to the facility on 11/28/17. R10's file lacked documented evidence of a medication review every six months. On 10/07/21 in the morning, the Administrator and Employee #1 acknowledged medication reviews had not been completed every 6 months for R1, R2, R3, R4, R6, R7, R8, R9 and R10. Severity: 2 Scope: 3			