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 _____	12/18/2023

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 completed at your facility on 12/18/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten beds for elderly and disabled and/or persons with chronic illness and/or persons with mental illness, 3 Category I residents and 7 Category II residents. The census at the time of survey was eight. Eight resident files and six employee files were reviewed. The facility received a grade of D. 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.	0000		
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 premises were clean and well maintained. Findings include: The following observations were made on 12/18/23 in the backyard: - Excessive weeds measuring approximately six inches throughout the side yard. - 3 car batteries. - A empty birdcage. - 4 discarded chairs. - An exercise bike. - A shelf rack. - A pile of dried out wood planks. - Stacks of roof tiles. On 12/18/23 in the morning, the Administrator acknowledged the premises had not been well maintained and the items in the backyard needed to be cleaned up. Severity: 2 Scope: 3	0178	1) In order to correct the specific findings stated in the SOD the backyard will be cleaned up. The weeds, car batteries, shelf racks, discarded chairs, excercise bike, shelf rack, dried out wood planks and roof tiles will be removed. 2) To ensure the deficient practice does not recur all staff will monitor the cleanliness of the backyard daily. 3) To monitor the cleanliness of the backyard the staff will check the backyard daily. This will be reiterated in the weekly staff meeting. 4) The Administrator will be responsible for ensuring the POC is implemented and the backyard will be cleaned and maintained. 5) The corrective action was completed January 12, 2024.	01/12/2024

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0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview the facility failed to ensure a resident's bedroom window and a bathroom window had a screen. Findings include: On 12/18/23 in the morning, a tour of the facility revealed Resident #3's bedroom window was without a screen and a bathroom window had a ripped screen. On 12/18/23 in the morning, the Administrator acknowledged the missing screen for R3's bedroom window and the ripped screen on a bathroom window. Severity: 2 Scope: 1	0179	1) In order to correct the specific SOD the window screen in a bathroom and bedroom #3 will be replaced with new window screens. 2) To ensure the deficient practice does not recur the staffs will notify the administrator if there's any broken or missing window screens so it can be replaced immediately. 3) To monitor that there's no missing window screens or ripped screens the staff will check all the windows periodically. 4) The Administrator will be responsible in ensuring the POC is implemented that all windows have screens. 5) The corrective action was completed January 12, 2024.	01/12/2024
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on interview and record review, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7 and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/31/22, with diagnoses including hypertension and coronary artery disease. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 11/18/23 with diagnoses including cerebral vascular accident, cerebral infraction and lupus. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on 01/27/20, with diagnoses including coronary artery disease and hypertension. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 04/07/18, with a diagnosis of congestive heart failure. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 01/13/20, with diagnoses	0515	1) In order to correct the specific findings stated in the SOD the facility will develop a person-centered service plan for 8 0f 8 residents. 2) To ensure the deficient practice does not recur the facility will develop a person-centered service plan and review the person-centered service plan at least once a year. 3) To monitor and ensure the deficient practice will not recur all residents' charts will be reviewed and check to assure a person-centered service plan was developed for all the residents. 4) The Administrator will be responsible for ensuring the POC is implemented that a person-centered service plan were developed for 8 0f 8 residents. 5) The corrective action of developing a person-centered service plan for 8 of 8 residents was completed by January 5, 2024.	01/05/2024

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	including gastroesophageal reflux disease, arthritis, chronic pain, and anxiety. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 1/16/19, with diagnoses including hypertension and gastroesophageal reflux disease. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 10/28/17, with diagnoses including atrial fibrillation, hypothyroid, anxiety and depression. R7's file lacked a person-centered care plan. Resident #8 (R8) R8 was admitted to the facility on 11/30/23, with diagnoses including senile degeneration of the brain, atrial fibrillation, and dysphagia. R8's file lacked a person-centered care plan. On 12/18/23 in the afternoon, the Administrator acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7 and R8. Severity: 2 Scope: 3			
0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure full bed rails were not used as a restraint for 1 of 8 residents (Resident #4). Findings include: Resident #4 (R4) was admitted on 04/07/18 with diagnoses including dementia. On 12/18/23 in the afternoon, R4 was observed lying in bed, with full bed rails up on both sides of the bed. R4 indicated they did not know how to lower the bedrails. On 12/18/23 in the afternoon, the Administrator confirmed full rails were in use for R4, and acknowledged they should not be in place. Severity: 2 Scope: 1	0557	1) In order to correct the specific findings stated in the SOD the full bed rails on both sides will be lowered and will not be used as a restraint for Resident #4. 2) To ensure the deficient practice does not recur all staff will be informed and educated that full bed rails are to be lowered and not be use as a restraint at all times. 3) To monitor that the deficient practice will not recur the staff will check and make sure that full bed rails are lowered and not being used as a restraint. 4) The Administrator will be responsible for ensuring the POC is implemented that full bed rails are lowered and not being used as a restraint. 5) The corrective action of not using full bed rails as a restraint and making sure full bed rail are lowered was completed December 18, 2023.	12/18/2023

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0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure Oxygen tanks were secured. Findings include: On 12/18/23 in the morning, there were two Oxygen tanks unsecured in the closet of Resident #5's (R5) bedroom. On 12/18/23 in the morning, the Caregiver acknowledged the two tanks should have been secured. Severity: 2 Scope: 1	0690	1) In order to correct the specific findings stated in the SOD the two unsecured oxygen tanks in the closet of Resident #5's bedroom were placed in oxygen cylinder cart and secured. 2) To ensure the deficient practice does not recur the staff will check all the bedrooms and closets that all oxygen cylinder are secured in oxygen cylinder carts. 3) To monitor that the deficient does not recur the staff will check all the bedrooms and closets that all cylinder are secured in oxygen cylinder carts daily. 4) The Administrator will be responsible for ensuring the POC is implemented that all oxygen cylinders area always secured and in a oxygen cylinder cart. 5) The corrective action of securing the two unsecured oxygen tanks in the closet of Resident 5's bedroom was completed 12/18/2023.	12/18/2023
0870 SS= E	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of	0870	1) In order to correct the specific findings stated in the SOD the facility will ensure a	12/18/2023

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	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 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 record review and interview, the facility failed to ensure a medication regimen review was completed for 4 of 8 residents (Resident #1, #5, #6 and #7). Resident #1 (R1) R1 was admitted to the facility on 01/31/22, with diagnoses including hypertension and coronary artery disease. R1's file documented the last medication regimen review was on 06/30/22. R1's file lacked documented evidence of a current 6-month medication regimen review by a physician, pharmacist, or registered nurse, which included a written report for review by the Administrator. Resident #5 (R5) R5 was admitted to the facility on 01/13/20, with diagnoses including gastroesophageal reflux disease, arthritis, chronic pain, and anxiety. R5's file lacked documented evidence of a 6-month medication regimen review by a physician, pharmacist, or registered nurse, which included a written report for review by the Administrator. Resident #6 (R6) R6 was admitted to the facility on 1/16/19, with diagnoses including hypertension and gastroesophageal reflux disease. R6's file lacked documented		medication regimen review is completed for Resident #1, #5, #6, #7at least once every 6 months. 2) To ensure the deficient practice does not recur the Resident #1, #5, #6, #7 charts will be reviewed in the weekly staff meetings to ensure that the medication regimen review is completed at least once every 6 months. 3) To monitor and ensure the deficient practice will not recur, the Resident #1, #5, #6, #7 chart will be reviewed during the weekly staff meeting to ensure that the medication regimen review is completed at least once every 6 months. 4) The Administrator will be responsible for ensuring the POC is implemented that the a medication regimen review is completed for all the residents at least once every 6 months. 5) The corrective action of completing a medication regimen review for Resident #1, #5, #6, #7 was completed 12/18/2023.	

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	evidence of a 6-month medication regimen review by a physician, pharmacist, or registered nurse, which included a written report for review by the Administrator. Resident #7 (R7) R7 was admitted to the facility on 10/28/17, with diagnoses including atrial fibrillation, hypothyroid, anxiety and depression. R7's file lacked documented evidence of a 6-month medication regimen review by a physician, pharmacist, or registered nurse, which included a written report for review by the Administrator. On 12/18/2023 in the afternoon, the Owner acknowledged the files for R1, R5, R6 and R7 lacked documented evidence of a 6-month medication regimen review by a physician, pharmacist, or registered nurse, which included a written report for review by the Administrator. Severity: 2 Scope: 2			

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0885 SS= E	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure medications were destroyed for 2 of 8 Residents (Resident #2 and #3). Findings include: Resident #2 (R2) R2 was admitted on 11/18/23, with diagnoses including cerebral vascular accident, cerebral infraction and lupus. R2's medication container contained a bottle of Docusate Sodium 100 milligram (mg). The December 2023 MAR documented Docusate Sodium 100 mg, take 1 capsule by mouth twice a day hold for loose stools. The medication was not documented on the MAR as being administered to R2 in the month of December. A Medication Reconciliation Summary dated 12/06/23 documented Docusate Sodium 100 mg was not a current medication. Resident #3 (R3) R3 was admitted on 01/27/20, with diagnoses including coronary artery disease and hypertension. R3's bedside table contained Nystatin ointment 100000, apply to affected area(s) topically twice per day. The December 2023 MAR documented the medication was discontinued. The Hospice Medication List summary dated 10/10/23 lacked documented evidence the Nystatin should have been administered. On 12/18/23 in the afternoon, the Administrator acknowledged R3's medications Docusate Sodium and Nystatin needed to be destroyed because they had been discontinued by the physician. Severity: 2 Scope: 2	0885	1) In order to correct the specific findings stated in the SOD the facility destroyed the discontinued medications for Resident #2 and #3. 2) To ensure the deficient practice does not recur the facility will destroy the discontinued medications of all the residents immediately. 3) In order to monitor and ensure the deficient practice will not recur the facility will review and make sure that all the discontinued medications are not in the resident's medication box and destroy the discontinued medications immediately. This will be reiterated in the weekly staff meeting. 4) The Administrator is responsible for ensuring the POC is implemented. That all discontinued medications for all residents are destroyed. 5) The corrective action of destroying the discontinued medications for Resident #2 and #3 have been completed in 12/18/2023.	12/18/2023

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0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured. Findings include: On 12/18/23 in the morning, the following medications were found unsecured in a refrigerator: - Morphine 1R 20 mg/mL, take 0.5 mL(10 mg) by mouth every hour as needed for pain. - Morphine 1R 20 mg/mL, take 0.25 mL(5 mg) by mouth/under the tongue every 4 fours as needed for pain/shortness of breath. - Haloperidol con 2mg/mL, give 0.5 mL(1 mg) by mouth/under the tongue every 4 hours as needed for agitation/nausea. - Lorazepam con 2mg/mL, give 0.5 mL(1 mg) by mouth/under the tongue every hour as needed for anxiety. On 12/18/23 in the morning, the Caregiver acknowledged the medications were unsecured and reported they should have been locked up. Severity: 2 Scope: 3	0920	1) In order to correct the specific findings stated in the SOD the facility placed all the unsecured medications found in the refrigerator in a secured, locked box. 2) To ensure the deficient practice does not recur the staff will check and double check that all medications are locked and secured. 3) To monitor and ensure the deficient practice does not recur the staff will check and double check that all medication are locked and secured. This will be reiterated in the weekly staff meeting. 4) The Administrator will be responsible for ensuring the POC is implemented and all medication are locked and secured at all times. 5) The corrective action was completed and all the medications in the refrigerator were placed in a locked and secured box in 12/18/2023.	12/18/2023
0933 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be	0933	1) In order to correct the specific findings stated in the SOD the facility obtained a Physician Placement Determination form for Resident #1, #3, #4, #5, #6 and #7. 2) To ensure the deficient practice does not	01/05/2024

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	maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (d) A statement from the resident ' s physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. Inspector Comments: Based on interview and record review, the facility failed to obtain a Physician Placement Determination upon admission for 6 of 8 residents (Resident #1, #3, #4, #5, #6 and #7). Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/31/22, with diagnoses including hypertension and coronary artery disease. R1's file lacked a Physician Placement Determination form. Resident #3 (R3) R3 was admitted to the facility on 01/27/20, with diagnoses including coronary artery disease and hypertension. R3's file lacked a Physician Placement Determination form. Resident #4 (R4) R4 was admitted to the facility on 04/07/18, with a diagnosis of congestive heart failure. R4's file lacked a Physician Placement Determination form. Resident #5 (R5) R5 was admitted to the facility on 01/13/20, with diagnoses including gastroesophageal reflux disease, arthritis, chronic pain, and anxiety. R5's file lacked a Physician Placement Determination form. Resident #6 (R6) R6 was admitted to the facility on 1/16/19, with diagnoses including hypertension and gastroesophageal reflux disease. R6's file lacked a Physician Placement Determination form. Resident #7 (R7) R7 was admitted to the facility on 10/28/17, with diagnoses including atrial fibrillation, hypothyroid, anxiety and depression. R7's file lacked a Physician		recur the facility will include a Physician Placement Determination in the pre admission forms that needs to be completed for future residents. The facility will make sure that all the residents have a Physician Placement Determination form filled out. 3) To monitor and ensure that the deficient practice will not recur, that all residents have a Physician Placement Determination form, the facility will make sure that a Physician Placement Determination form is included in the pre admission forms for new and future residents. 4) The Administrator is responsible for ensuring the POC is implemented that Resident #1, #3, #4, #5, #6, #7 have a Physician Placement Determination Form filled out. 5) The corrective action of obtaining a Physician Placement Determination form for Resident #1, #3, #4, #5, #6, #7 was completed on January 5, 2024.	

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(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
	Placement Determination form. On 12/18/23 in the afternoon, the Administrator acknowledged a Physician Placement Determination was not obtained for R1, R3, R4, R5, R6 and R7. Severity: 2 Scope: 3			
1840 SS= F	UNL Caregiver Training Inspector Comments: Based on record review and interview, the facility failed to ensure that Employee #2, #3 and #4 acquired the required infection control training. Findings include: Employee #2 (E2) E2 was hired on 12/13/17 as a Caregiver. E2's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #3 (E3) E3 was hired on 03/23/22 as a Caregiver. E3's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. Employee #4 (E4) E4 was hired on 09/05/18 as a Caregiver. E4's employee file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. On 12/18/23 in the afternoon, the Administrator confirmed the required infection control and prevention training had not been completed for E2, E3, and E4. Severity: 2 Scope: 3	1840	1) In order to correct the specific findings stated in the SOD the Employee #2, #3, #4 completed the required infection control and prevention training. 2) To ensure the deficient practice does not recur the facility will make sure that all future Employees will complete the required infection and prevention training. 3) To monitor and ensure the deficient practice will not recur the required infection and prevention training will be given to all employees and the certificate will be in their employee file. The importance of the required infection and prevention training will be reiterated in the weekly staff meetings. 4) The Administrator is responsible for ensuring the POC is implemented, that Employee #2, #3, #4 have completed the infection and prevention training. 5) The corrective action was completed January 6, 2024. Employee #2, #3, #4 completed the infection control training. 5) The corrective action was completed on 12/23/2023. Employee #2, #3, #4 completed the infection and prevention training.	01/06/2024