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 _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS HOUSE ADULT CARE	**5496 TAMARUS 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 a complaint investigation initiated at your facility on 07/30/18 and completed on 07/31/18, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine Resident Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of investigation was six. There was one complaint investigated. Complaint #NV00053384 could not be substantiated. Allegation #1 the facility was not wheelchair accessible. Allegation #2 two bathrooms in resident's area were ant-ridden. Allegation #3 there was no toilet seat in bathroom #1 rendering it unusable for women and a cracked toilet seat in bathroom #2. Allegation #4 the second bathroom had leaky sink faucet, water leaked onto the floor, creating a slip hazard. Allegation #5 the food was of poor quality, with an eye towards economy rather than nutrition or being appetizing. Allegation #6 the lighting was dim and insufficient. Allegation #7 lack of activities, there was no attempt to engage residents in socialization or activities. The investigation into the allegations included: Observation of the facility's hallways, ramps, lighting in common areas and residents' during the hours in between meals. Interviews were conducted with two residents, two House Managers, one Caregiver, one Nurse Practitioner and one Case Manager both from a resident's primary physician clinic. Review of five resident records including the resident of concern. Review of the facility's calendar of activities. Deficiencies unrelated to the complaint were identified during the investigation (See Tags Y532 and Y622). The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: BRAD BOMAN Title: Administrator Date: 10/02/2018

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.

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 _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS HOUSE ADULT CARE	**5496 TAMARUS 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
	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:			
0532 SS= C	449.260(1)(g)(1)(2) - Activities for Residents - NAC 449.260 Activities for residents. 1. The caregivers employed by a residential facility shall: (g) Post, in a common area of the facility, a calendar of activities for each month that notifies residents of the major activities that will occur in the facility. The calendar must be: (1) Prepared at least a month in advance. (2) Kept on file at the facility for not less than 6 months after it expires. Inspector Comments: Based on observation and interview, the facility failed to post the current month's calendar of activities. Findings include: On 07/30/18, in the morning, the facility did not have a calendar of activities for July 2018. The Activity Calendar posted was for May and June 2018. From 9:30 AM to 12:00 PM, House Manager #1 indicated the activity calendar was in the computer but was unable to print. Severity: 1 Scope: 3	0532	I have uploaded a September 2018 Activity Calendar. House manager # 2 will prepare and post an Activity Calendar each month to be checked by the Administrator. The Calendars will be posted and saved for review every month.	09/01/2018
0622 SS= D	449.2702(4)(c) - Admission Policy - NAC 449.2702 Written policy on admissions; eligibility for residency. 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (c) Requires confinement in locked quarters. Inspector Comments: Based on observation, interview, record review and document review, the facility failed to ensure 1 of 5 residents who exhibited exit-seeking behavior was not admitted to the facility and not retained in the facility (Resident #2). Findings include: Resident #2 Resident #2 (R2) was admitted on 07/06/18, with diagnoses including metabolic encephalopathy, memory loss	0622	Resident # 2 was disoriented on admission. Staff worked with Family members to try to Re-Orient her to her new surroundings. She is on half hour checks now by staff. House manager # 2 takes her out shopping Etc. 3-4 times per week (To various locations).House managers # 1 & #2 are attempting to find psychiatric help for her but due to Insurance issues a Doctor has not been found who will treat her. Follow ups with her primary Insurance company have taken place and will continue until a Psychiatrist is found to diagnose her and prescribe effective medicine . At the moment with outings and close supervision she is compliant. Her Family has been hesitant to accept responsibility to help.	09/30/2018

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 _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS HOUSE ADULT CARE	**5496 TAMARUS 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
	and high blood pressure. The History and Physical Examination from a skilled nursing facility dated 06/28/18, documented R2 was brought to a hospital when the resident was found wandering on the street and was noted to be confused. The resident was diagnosed with altered mental status, severe hyponatremia and hypokalemia. On 07/30/18 at 9:45 AM, during a facility tour, R2 was not in their bedroom. The Caregiver reported R2 wandered out of the facility the day before and rushed out to the front yard to look for R2. At around 9:55 AM, House Manager #1 arrived. At 10:00 AM, House Manager #1 asked the Caregiver to find R2. At 10:20 AM, the Caregiver came back and reported R2 was not at the nearby grocery store. At 10:25 AM, the House Manager notified the family R2 was missing. On 07/30/18 at 10:05 AM, House Manager #1 indicated R2 had several incidents of living the facility without notifying the Caregiver: On 07/26/18, R2 left at 2:00 PM and walked to the nearby school. The Caregiver brought the resident back to the facility and explained it was not safe for R2 to walk around because of the heat. On 07/28/18, the family found R2 at the front gate. The family brought R2 inside the facility and stayed home the rest of the day. On 07/29/18 at around 8:45 AM, the Caregiver realized R2 was not in the bedroom. The House Manager notified the family. The family checked the resident's bank account and found a recorded transaction at a grocery store about two miles away from the facility. The family went to pick-up R2 but did not find R2. At around 2:30 PM, the family checked R2's bank account and found a transaction recorded 15 miles North of the facility. The Owner brought the resident back to the facility after 8:00 PM. The Standard Placement Determination dated 07/02/18, signed by a physician, documented R2 required a residential facility which provided care to persons who were elderly or disabled or who required assistance or protective supervision,		Angel House staff will continue to closely monitor her during this period while Medical help is being sought. I have uploaded a List of Half Hour Checks done for Resident 2. She is doing much better now after she had an appointment the a Psychiatrist. She is has always been fine at night and the outings during the week have given her the Activities out of the Facility she needs. We have had no problems or even her wanting to go off by her self. The Outings are being done per the attached schedule and have made R 2 compliant with House Rules. Employee 1 and 2 are taking dual responsibility to insure continued compliance with house rules. All corrective actions were completed by 09/30/18.	

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 _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS HOUSE ADULT CARE	**5496 TAMARUS 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
	because they suffered from infirmities or disabilities. The facility's Needs Assessment dated 07/06/18 documented R2 did not require protective supervision, able to make needs known, able to follow instructions and was oriented. The Needs Assessment did not consider the hospital's report about R2's history of wandering and did not follow the physician's placement recommendation. On 07/30/18 at 10:20 AM, when asked if House Manager #1 was aware that before R2 moved-in, R2 was brought to the hospital after R2 was found wandering on the street, the House Manager acknowledged they did not read the skilled nursing report thoroughly. On 07/30/18 at 3:15 PM, the Nurse Practitioner (ARNP) at R2's primary care physician's clinic, indicated when the ARNP saw R2 on 07/17/18, R2 was attached to the Manager who accompanied the resident. The ARNP reported R2 kept saying "don't leave me." The ARNP reported the resident had memory changes and "probably dementia." The RN Case Manager at the same clinic indicated on 07/26/18, the facility notified the RN Case Manager R2 indicated R2 had a gun and was going to kill self. The Nurse Practitioner's Visit Notes on 07/17/18, for post hospitalization follow-up, documented R2's assessment included memory loss, hypokalemia and high blood pressure. The ARNP reported R2 did not seem to remember the hospital stay, did not remember where R2 lived and did not recognize R2's primary care physician's name. On 07/30/18 at 4:18 PM, House Manager #2 notified the inspector R2 was back in the facility. R2 went to a store about two miles away from the facility. Someone called the facility while R2 was at the bus stop and House Manager #2 picked-up R2. On 07/30/18 at 4:20 PM, Resident #2 (R2) reported leaving the facility at 9:30 AM because the resident got too bored. R2 walked around, took a bus and tried to find a place to get a phone. R2 reported on 07/29/18 the resident did a lot of walking			

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 _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS HOUSE ADULT CARE	**5496 TAMARUS 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
	and was picked up by police. R2 called House Manager #2 who brought the resident home. Severity: 2 Scope: 1			