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
	4093	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JCR HOME CARE INC	7160 DARBY AVE, LAS VEGAS, NEVADA ,89117

(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 survey initiated at your facility on August 23, 2018. This state licensure annual survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was ten. The facility is licensed as a ten bed residential facility for groups with an Alzheimer's Disease endorsement, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and five employee files were reviewed. The facility received a grade of A. 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 deficiencies were identified:	0000		

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 REPRESENTATIVE'S SIGNATURE Name: JASMINE CASTILLO Title: Administrator Date: 09/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4093	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JCR HOME CARE INC	7160 DARBY AVE, LAS VEGAS, NEVADA ,89117

(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
0531 SS= F	449.260(1)(f) - Activities for Residents - NAC 449.260 Activities for residents. 1. The caregivers employed by a residential facility shall: (f) Encourage the residents to participate in the activities scheduled pursuant to paragraph (e). Inspector Comments: Based on observation, interview and record review, the facility failed to ensure activities on the activity calendar were followed and failed to ensure residents were asked to participate in activities. Findings include: On 8/23/18 at 9:02 AM, seven residents were seated in the living room watching television. The facility had an activity calendar on the bulletin board. The activity listed for the day was to play dominos. The calendar documented gardening as an activity for five days for the month of August 2018. The backyard lacked a vegetable or flower garden. On 8/23/18 at 9:20 AM, the caregiver was in the backyard and pointed to a small bush and weeds explaining this was the garden. The caregiver then explained it was too hot to grow a garden resulting in the facility not having a garden. On 8/23/18 at 9:25 AM, a resident sitting in the living room explained the facilty did not provide activities. The resident wanted to play dominos, but the staff had not asked and had not gardened while at the facility. On 8/23/18 at 9:27 AM, a resident was sitting in the living room explained activities would be a good thing to do, but none were offered. The resident was younger and was not diagnosed with Alzheimer's Disease. On 8/23/18 at 9:30 AM, a resident sitting on the couch reported no activities were initiated by the staff. On 8/23/18 at 10:00 AM, a resident was in the resident's bedroom and explained activities would be nice. No staff came around and informed the residents of activities. On 8/23/18 at 2:00 PM, the Administrator explained most of the residents like to watch television or did not want to participate in the activities provided. Severity: 2 Scope: 3	0531	1) The facility will correct this deficiency by encourging all resident will do our daily activities especially the residents who are active . 2) To ensure the deficiency does not reacur again the facility staff will encourage all residents will do daily actives especially the active residents . 3) The administrator and the facility staff will monitor to ensure that the deficient will not recur. 4) The administrator will ensure the plan of correction will be implemented . 5) Sept. 2, 2018	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4093	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JCR HOME CARE INC	7160 DARBY AVE, LAS VEGAS, NEVADA ,89117

(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
0625 SS= D	Blank - Inspector Comments: Based on observation, interview and record review, the facility failed to ensure resident who were bed fast had a bed fast waiver for 2 of 10 residents. (Resident #7 and Resident #8). Findings include: Resident #7 Resident #7 was admitted on 12/1/14, with diagnoses including seizure and dementia. On 8/23/18 at 10:30 AM, the resident was laying in bed with half rails up. The Administrator instructed the resident to grab the bed rail with the left hand. The resident could not comply with the instruction. The resident was unable to move in the bed without assistance. The resident's cognitive assessment (dated 4/20/18) documented the resident was completely dependant for all care The resident's clinical record lacked documented evidence of a bedfast waiver. On 8/23/18 at 10:35 AM, the Administrator verified the resident did not have a bedfast waiver. The resident was on hospice and the agency was getting the paper work together to obtain the bedfast waiver. The caregivers came in and turned the resident every two hours. Resident #8 Resident #8 was admitted on 3/13/18, with a diagnoses of Alzheimer's Disease. On 8/23/18 at 10:45 AM, the resident was laying in bed with half side rails up. The Administrator asked the resident to move side to side. The resident was unable to follow the instructions. The resident's clinical record lacked documented evidence of a bedfast waiver. The clinical record documented the resident's cognitive level as zero. On 8/23/18 at 10:47 AM, the Administrator explained the resident was unable to move side to side without assistance. The resident would scream if the caregivers moved the resident. The Administrator verified the resident did not have bedfast waiver. The resident was on hospice and the agency had not provided the documents to the facility to obtain the bedfast waiver. On 8/23/18 at 11:15 AM, a hospice worker verified the resident was bedfast and would get in contact with the agency to get the paper work for the bedfast waiver. Severity: 2 Scope: 1	0625	1) The facility will correct by any of resident who are Bedfast should apply right to Carson City for a Bedfast waiver as soon any resident is not capable to move independently. Both residents already applied Bedfast waiver and been approved with limitation only for 1 year and renewable every year. 2) To ensure that the deficiency will not recur again the facility will apply right away for Bedfast Waiver when resident is not capable to move independently with the caregiver help. 3) The corrective action will be monitored to ensure the deficiency practice will not recur the facility will apply right away for any resident who required Bedfast Waiver. 4) The administrator will ensure the plan of correction is implemented. 5) Sept. 7, 2018 6) Please see attachment of two residents Bedfast Waiver Approval.	09/07/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4093	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JCR HOME CARE INC	7160 DARBY AVE, LAS VEGAS, NEVADA ,89117

(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
0626 SS= D	Blank - Inspector Comments: Based on observation and interview, the facilty failed to ensure a resident was not restrained in a wheelchair for 1 of 10 residents (Resident #2). Findings include: Resident #2 was admitted to the facility on 3/1/18, with a diagnosis of Dementia with behavioral disturbances. On 8/23/18 at 12:15 PM, the resident was sitting in a wheelchair behind the couch watching television. The resident had a belt across the resident's lap. The belt was secured through the arms of the wheelchair. The Administrator asked the resident to unclasp the belt three times. The resident did not understand the instructions until the third request. The resident attempted to unclasp the belt and was unable to complete the task. On 8/23/18 at 12:18 PM, the resident explained the resident could not unclasp the belt. On 8/23/18 at 12:20 PM, the Administrator explained the resident was able to walk around the facility a few weeks ago. The resident fell and was getting weak. The Administrator put the belt on the wheelchair so the resident could not get up and walk around the facility and fall. Severity: 2 Scope: 1	0626	1) The facility removed the wheelchair belt on the day of the survey and no intention on putting it back on . 2) The facility will make sure that any residents who are wondering will just have staff to keep on eye on the resident at all time. 3) The facility will correct the deficiency to ensure will not recur by keeping on eye resident who are wonderer and high risk resident at all time. 4) The Administrator is responsible to ensure the plan of correction will be implemented . 5) Aug. 23, 2018	08/23/2018
0675 SS= D	449.2708(4)(a)(b) - Discharge of Resident - NAC 449.2708 Discharge of resident; notice of discharge; issuance of notice to quit to resident for improper or harmful behavior. 4. If the resident or any of his visitors are engaging in behavior which is a threat to the mental or physical safety of the resident or other persons in the facility, the facility may issue a notice to quit to the resident. The notice to quit must include: (a) The reasons for its issuance, with specific facts relating to the date, time and place of the incidents that posed a threat to the physical or mental health or safety of the resident or other persons in the facility. (b) The names of persons who witnessed the incidents and the circumstances under which the incidents occurred. If the resident or his visitors do not comply with the notice to quit, the resident may be discharged without his approval pursuant to subsection 2. Inspector Comments: Based on interview	0675	1) Resident #3 was discharge from the facility when her she went to the hospital and needed more of skilled nursing services as what the hospital suggested . Resident #4 is searching for Mental illnes endorse Group Home that will accept him and once he will find another place he will be moving to a mental illness endorse Group Home as soon as possible . 2) The facility will not admit any resident who is not diagnose with Dimentia or Alzheimer or any resident who will not understand or willing to get along with seniors to ensure the deficiency will not recur . 3) The administrator will make sure before admitting any resident to the facility the resident must be willing to share and understand about living in an Alzheimer's Group Home. 4) The administrator is responsible for ensuring the plan of correction is implemented.	09/12/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4093	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JCR HOME CARE INC	7160 DARBY AVE, LAS VEGAS, NEVADA ,89117

(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 record review, the facility failed to ensure 2 of 10 residents were appropriate for the facility (Resident #3 and #4). Findings include: Resident #3 Resident #3 was admitted on 6/13/18, with diagnoses including seizure disorder and hypertension. The resident's clinical record documented the resident does not need protective supervision and was alert and oriented to people, place and time. On 8/23/18 at 9:15 AM, the resident was in the living room watching television and explained the facility was not an appropriate place. The resident did not have a diagnoses of Alzheimer's Disease and wanted to be discharged to another facility. On 8/23/18 at 11:00 AM, the Administrator explained the resident had a Public Guardian who was aware the resident wanted to be discharged from the facility. The Administrator reported an incident, which occurred two days after the resident was admitted in June 2018. Resident #2 was walking around the facility and Resident #3 yelled at the resident. A few days later Resident #2 urinated on the floor and Resident #3 yelled at the resident. Both of these incidents scared Resident #2. The Administrator expressed the opinion both of these incidents caused Resident #2 to decline and would only sit in the wheelchair. The Administrator verified a 30 day notice to discharge the resident was not provided to the Public Guardian and verified the facility policy was to issue a 30 day notice if a resident became abusive to another resident. Resident #4 Resident #4 was admitted to the facility on 4/10/18, with diagnoses including bipolar and schizophrenia. The resident's clinical record documented the resident was alert to people, place an time. On 8/23/18 at 9:30 AM, the resident was in the living room watching television. The resident explained the facility was not appropriate, but wanted to stay at the facility. The resident wanted to be able to ride public transportation to an anger management class which was mandatory for the resident. On 8/23/18 at 11:00 AM, the Administrator explained the resident was placed in the facility by Elder Protective Services. The resident attended anger management classed due to an		5) Sept. 6, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4093	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JCR HOME CARE INC	7160 DARBY AVE, LAS VEGAS, NEVADA ,89117

(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
	incident with the resident's wife where the resident was yelling at the wife. Severity: 2 Scope: 1			