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 _____	12/17/2024

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 State Licensure survey conducted at your facility on 12/17/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was 10. Ten resident files and four employee files were reviewed. The facility received a grade of B. 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 regulatory deficiencies were identified:	0000		

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 _____	12/17/2024

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
0106 SS= F	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 4 employees received in person cardiopulmonary resuscitation (CPR) training. (Employee #1, #2, #3 and #4) Findings include: Employee #1 (E1) E1 was hired on 08/01/94 as the Administrator. E1's file revealed CPR training was completed online on 12/03/24. E1's record lacked documented evidence of the CPR in person component. Employee #2 (E2) E2 was hired on 08/01/24 as a Caregiver. E2's file revealed CPR training was completed online on 08/21/24. E2's record lacked documented evidence of the CPR in person component. Employee #3 (E3) E3 was hired on 04/21/10 as a Caregiver. E3's file revealed CPR training was completed online on 12/03/24. E3's record lacked documented evidence of the CPR in person component. Employee #4 (E4) E4 was hired on 08/05/13 as a Caregiver. E4's file revealed CPR training was completed online on 12/03/24. E4's record lacked documented evidence of the CPR in person component. On 12/17/24 in the afternoon, the Administrator confirmed the online CPR with no in person component for E1, E2, E3 and E4 and acknowledged the in person component was required to be in compliance. Severity: 2 Scope: 3	0106	1. The facility well, correct the specific finding by taking a CPR class in person via our local company that we always use. All caregivers took the in person class and was able to get our certification last Friday Jan. 3,2025. 2. To ensure that the deficiency will not reoccur, the administrator will no longer using online CPR classes. It has to be in person classes. 3. In order the corrective action will be monitored to ensure that deficient practice does not recur the administration will not sign up any online CPR class , it should be on actual class setting. 4.The Administrator , responsible for ensuring the plan of correction is implemented. 5. Jan. 3, 2024 6. Please see the attachment.	01/09/2025

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 _____	12/17/2024

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
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 was clean and maintained. Findings include: On 12/17/24 in the morning, during a tour of the facility the following was observed: -The kitchen microwave over the stove was dirty with old food debris -The oven in the kitchen had old caked on grime inside and on the doors -The screening surrounding the patio in the backyard had multiple areas where the mesh was missing and/or torn - There were miscellaneous objects in the backyard, including a broken chair, a clear glass or plastic panel, multiple hoses and multiple unidentified broken objects in the corner of the backyard On 12/17/24 in the morning, a Caregiver reported the microwave above the stove was not in use and acknowledged the dirty oven. On 12/17/24 in the afternoon, the Owner acknowledged the observations in the backyard and kitchen. Severity: 2 Scope: 3	0178	1. The facility well, correct the specific finding the kitchen microwave oven , the stove, the oven in the kitchen was all been cleaned up on the same day of the survey . The screening surrounding of the patio has been add on all the missing and replace all the torn. All the objects in the backyard was cleaned and put to trash . 2. To ensure that the deficiency will not reoccur, the administrator will make sure that the surrounding in the kitchen must be clean at all times, and the yard of all surrounding must be cleaned at all times. 3. In order the corrective action will be monitored to ensure that deficient practice does not recur the administration will check and monitor the facility at all times and make sure all the kitchen is clean and the backyard of the surrounding area must be clean. 4.The Administrator , responsible for ensuring the plan of correction is implemented. 5. Jan. 6, 2025 6. Please see the attachment.	01/09/2025
0936 SS= E	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 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure 3 of 10 residents met	0936	1. The facility well, correct the specific finding R2 and R8 chest X-ray was given with the result enclosed. R1 , had a quantiferon when she went to the hospital and I requested to have the quantiferon with the results was indeterminate R1 doctor requested for tb chest X-ray with no sign of active tb results. Please see attachment. 2. To ensure that the deficiency will not reoccur, the administrator will have to follow **NAC 441A.380 guidelines.** **3. In order the corrective action will be monitored to ensure that deficient practice does not recur the administration will make sure all paperwork must be on file at all times.** **4.The Administrator , responsible for ensuring the plan of correction is implemented.** **5. FEB 25, 2025** **6. Please see the attachment.**	01/17/2025

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 _____	12/17/2024

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
	the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A. (Resident #1, #2, and #8) Findings include: Resident #1 (R1) R1 was admitted on 07/22/24 with diagnoses including chronic heart failure, dementia, hypertension and depression. R1's record documented a chest x-ray on 09/05/24 with a negative result. R1's record lacked documented evidence of a positive TB test. On 12/17/24 in the morning, the Administrator explained R1's physician reported R1 continued to refuse any blood or TB test. Resident #2 (R2) R2 was admitted on 12/18/23 with diagnoses including dementia, depression and anxiety. R2's record documented a first step TB test with an injection date of 06/02/23 and negative result and a second step TB test with an injection date of 06/09/23 and negative result. The two tests lacked documented evidence of read dates. Resident #8 (R8) R8 was admitted on 05/25/18 with diagnoses including dementia, depression, hypotension and blindness. R8's record documented a QuantiFERON test dated 06/25/24 with a positive result. R8's record lacked documented evidence of a negative chest x-ray after the positive result. The facility's Admission Agreement stated a cause for eviction included failure to comply with local and state law after receiving notice of the alleged violation. On 12/17/24 at 10:30 AM, the Administrator confirmed the incomplete TB tests for R2 and lack of negative chest x-ray for R8. The Administrator confirmed the lack of documented evidence of a positive TB test for R1, and explained there had been repeated requests to R1 from the Administrator and physician to complete a TB or QuantiFERON test. Severity: 2 Scope: 2			
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her	1600	1. The facility well, correct the specific finding R016-20 Section 19 resident records to reflect resident preferred name and pronoun, gender identity or expression and sexual orientation , the administrator made a new file admission to all 10 residents records. 2. To ensure that the deficiency will not reoccur, the administrator will make sure	01/09/2025

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 _____	12/17/2024

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
	preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. NAC 449.011946 Provision of certain statements, notices and information in appropriate languages and with reasonable accommodations. 1. Except as otherwise provided in subsection 2, the statements, notices and information required by NAC 449.011901 to 449.011951 inclusive, and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language		that all residents and future residents must have R016-20 Section 19 resident records to reflect resident preferred name and pronoun, gender identity or expression and sexual orientation admission record on file at all times. 3. In order the corrective action will be monitored to ensure that deficient practice does not recur the administration made a new R016-20 section admission file . 4.The Administrator , responsible for ensuring the plan of correction is implemented. 5. Dec. 18, 2024 6. Please see the attachment.	

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 _____	12/17/2024

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
	the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on record review and interview, the facility failed to ensure there were policies developed and resident records revised in compliance with R016-20 Section 19, regarding resident records to reflect resident preferred name and pronoun, gender identity or expression and sexual orientation. Findings include: On 12/17/24 in the morning, the ten sampled resident records lacked documentation to be in compliance with R016-20 Section 19. On 12/17/24 in the afternoon, the Administrator confirmed there were no updated policies or changes to resident records to reflect the new regulations. Severity: 1 Scope: 3			

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 _____	12/17/2024

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
1840 SS= E	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 4 employees received infection control training through a nationally recognized course. (Employee #3 and #4) Findings include: Employee #3 (E3) E3 was hired on 04/21/10 as a Caregiver. E3's record lacked documented evidence of infection control and prevention training. Employee #4 (E4) E4 was hired on 08/05/13 as a Caregiver. E4's record lacked documented evidence of infection control and prevention training. On 12/17/24 at 2:10 PM, the Administrator confirmed the missing infection control and prevention training for E3 and E4, and acknowledged the requirement for the infection control and prevention training. Severity: 2 Scope: 2	1840	1. The facility well, correct the specific finding by both caregivers 3 and 4 attended the infection control training on Dec. 31, 2024 . 2. To ensure that the deficiency will not reoccur, the administrator will make sure all caregivers must have annual infection control training on file at all times. 3. In order the corrective action will be monitored to ensure that deficient practice does not recur the administration will make sure all caregivers must have infection control training on file and done annually to all caregivers. 4.The Administrator , responsible for ensuring the plan of correction is implemented. 5. Dec. 31, 202 6. Please see the attachment.	01/09/2025