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 _____	**12/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVEL MANOR	**4935 N DURANGO, LAS VEGAS, NEVADA ,89149**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure, infection control and complaint investigation survey conducted at your facility and offsite from 12/09/21 to 12/10/21, 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 Elderly or Disabled Persons, Category II residents. The census at the time of the survey was eight. Eight resident files and seven employee files were reviewed. The facility received a grade of A. 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. Two complaints were investigated. Complaint #NV00065083 with nine allegations was unsubstantiated. Allegation #1. There was not enough staff to accommodate residents was unsubstantiated based on observation of resident/staff interactions, staffing schedule and interview with a Caregiver, the Executive Director and six residents who indicated staff are sufficient to accomplish all required tasks and resident assistance. Allegation #2. Residents are left sitting in soiled clothes or undergarments and some have developed pressure sores was unsubstantiated based on observation of residents who all had on clean clothes, record review which documented no	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: DAVID MARVEL Title: Administrator Date: 12/27/2021

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.

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	residents with changes of condition and interviews with a Caregiver, the Executive Director and six residents who indicated all needs are met timely and no resident ever sits in soiled clothing. Allegation #3. Residents are not provided oral care was unsubstantiated based on observation of available oral hygiene items and interviews with a Caregiver and six residents who indicated oral care was completed twice a day for all residents. Allegation #4. Residents are not showered and left wearing the same clothes for days was unsubstantiated based on observation of no odors in the facility and all residents wearing clean clothes, shower schedule documenting 2-3 showers per week and interviews with a Caregiver, the Executive Director and six residents who indicated showers are provided at least 2-3 times per week and more as needed. Allegation #5. The facility does not provide activities for residents was unsubstantiated based on review of activity calendar and interviews with a Caregiver, the Executive Director and six residents who indicated activities are provided daily in both a group setting and one on one. Allegation #6. Documentation of tuberculosis testing is fake/forged was unsubstantiated based on review of tuberculosis documentation and interview with the Executive Director who indicated many of the residents and staff had QuantiFERON testing and other tuberculosis testing was signed off by a nurse. Allegation #7. Employees do not receive training and certificates for training are falsified was unsubstantiated based on review of employee training certificates and interview with the Executive Director who indicated most training is conducted online and certificates are issued by outside agencies. Allegation #8. Medications have gone missing was unsubstantiated based on observation of all medications being available, review of physicians' orders and Medication Administration Record and interviews with a Caregiver, the Executive			

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	Director and six residents who indicated they always receive medication on time and as scheduled. Allegation #9. Facility maintenance is not done and family members have to buy and bring in items such as light bulbs was unsubstantiated based on observation of no maintenance issues in the facility, review of maintenance requests and interview with the Executive Director who indicated family members never had to fix any maintenance issues in the facility. The investigation into the allegations included: Observations of residents' cleanliness, oral hygiene product availability, staff/resident ratio, lack of odors and maintenance issues. Interviews with a Caregiver, the Executive Director and six residents. Review of facility incident reports, grievance reports, resident medical records, staff files, maintenance requests, activity calendar and staffing schedule. Complaint #NV00065385 with three allegations was substantiated without deficiency. Allegation #1. The facility does not notify family members of policy changes was unsubstantiated based on review of policy change document and interview with the Executive Director who indicted all families/residents sign a document about policy change notification in admission packet. Allegation #2. Visitation is restricted to one family being allowed to visit at a time was substantiated without deficiency based on review of facility visitation policy which documented visitation is limited to one family at a time due to COVID-19 restrictions and interview with the Executive Director who confirmed the facility policy for visitation. Allegation #3. Dementia residents walk into residents' rooms at night and take objects out of their room was unsubstantiated based on observation of dementia residents not entering other residents' rooms and interview with a Caregiver and Executive Director who indicated none of the residents enter other residents' rooms and staff are present 24 hours a day. The investigation into the			

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	allegations included: Observation of residents' movements throughout the facility. Interviews with a Caregiver and the Executive Director. Review of facility incident reports, grievance reports, medical records of residents with dementia diagnosis, facility visitation policy and admission packet forms. 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.			
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on interview and document review, the facility failed to ensure a written staffing schedule was retained for at least six months. Only the current month's staffing schedule was available and posted. The Executive Director acknowledged the facility did not have written schedules dating back six months. Severity: 1 Scope: 3	0088	1) Schedule posted 2) Assuring schedule is updated as needed 3) As above 4) House manager and Executive Director 5) 12/9/2021 6) See attached	12/09/2021
0690 SS= F	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)	0690	1) Assuring deliveries are set up correctly 2) Training staff on proper storage of oxygen 3) Monitor residents with oxygen - daily checks 4) House manager and Executive Director 5) 12/9/2021 prior to inspector leaving facility 6) See attached	12/09/2021

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	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 (O2) canisters were properly stored and secured. Two O2 canisters were found in a resident's room lying on the floor and six were found unsecured in the backyard. The Executive Director confirmed multiple O2 canisters in a resident's room and outside were not properly stored or secured. Severity: 2 Scope: 3			

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0960 SS= E	Alzheimer's Care Application for Endorsement - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer ' s disease. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure residents diagnosed with dementia had current standard placement documentation indicating they were safe to remain in the facility for 3 of 8 residents (Resident #2, Resident #4, and Resident #7). Findings include: Resident #2 (R2) was admitted on 08/28/21 with diagnosis including dementia with behaviors and anxiety disorder. There was no standard placement documentation in the record of R2 indicating they could be in a non Alzheimer's endorsed facility. Resident #4 (R4) was admitted on 01/28/18 with diagnosis including dementia and hypertension. R4's standard placement determination was last assessed in 2019. Resident #7 (R7) was admitted on 05/02/19 with diagnosis including dementia and insomnia. R7's standard placement determination was last assessed on 05/05/19. On 12/09/21 at multiple times, R7 was observed continually wandering from the living room, to the kitchen, to the backyard. On 12/09/21 at 12:40 PM, the Executive Director confirmed R2, R4 and R7 had dementia diagnoses and had not had a standard placement assessment upon admit for R2 and in over a year for R4 and R7. Severity: 2 Scope: 2	0960	1) DX prior to admission 2) Changed admit package to include waiver as needed 3) Added dates in a reminder program 4) Executive director and Administrator 5) 12/9/2021 corrected prior to inspector leaving the facility 6) See attached For #2 & #4 #7 no longer resides at the facility	12/09/2021