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
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108

(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 completed at your facility on 04/09/24, 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 and disabled persons and/or persons with mental illnesses, Category II residents. The census at the time of the survey was eight. Eight 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 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		
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure a background check was completed for 1 of 4 employees, per the requirement (Employee #1). Findings include: Employee #1 (E1) was hired on 11/10/21, as a Caregiver. E1's employee file had fingerprints dated 02/24/22, with no evidence of a clearance letter. On 04/09/24 in the morning, the Administrator acknowledged E1 did not have a background check and explained E1's fingerprints came back as not able to read and did not send E1 back for a second attempt. Severity: 2 Scope: 1	0104	1)The E1 got her first fingerprints on 02/24/22. No reports were received from the Fingerprinting place so when we contacted them they stated they were not able to read E1's fingerprints. They just stated E1 has to come back later to get a new set of fingerprints. E1 got a new set of fingerprints on 04/17/24, reports pending (Attachment A). If they are unable to read E1's fingerprints again, we will contact the appropriate person in charge and follow his/her instructions. 2) In the future, all applicants will meet the fingerprinting requirements as required. 3) We will use the new employee checklist (Attachment B) as the tool to make sure all requirements are met. 4) The administrator and the manger will be responsible for monitoring the corrective action. 5) 04/24/24	04/24/2024

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: MINKYUNG LIM Title: Administrator Date: 05/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108

(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
0430 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation, interview, and documented review, the facility failed to ensure the fire alarm was not impaired. Findings include: On 04/09/24 in the morning, the fire alarm trouble light was blinking yellow. The following fire inspection tags documented the following: 02/09/23 - Impairment. FACP (control panel) needs to be replaced. The same impairment had been documented on the inspection tags since 08/02/21. 07/10/23 - Deficiency replaced battery trouble remains. On 04/09/24 in the morning, the Manager reported a new fire alarm panel was ordered and was not aware when it would be installed. The Manager was not aware of the impairment until January 2024. On 04/09/24 in the morning, the fire alarm company explained FACP stood for the control panel. The company explained if the power went out the system's back up battery would not keep charge for long periods of time and needed to be replaced. Severity: 2 Scope: 3	0430	1) The fire system is being inspected and monitored on a regular basis. When we spoke with the company, they informed us that they have ordered a control panel so they can replace it. When we contacted them again, they stated they did not receive the parts that they would contact us back when all parts arrive. We asked if the fire system was working properly, (Attachment C) they assured us it is and that the control panel will be replaced. * On 04/30/24, they came to the facility and the panel has been replaced. 2) Systematic changes will be implemented to make sure inspections are not missed in the future. We will monitor each tags and inspection dates more closely so all fire system are in compliance. 3) We will monitor required inspections and arrange inspections dates at least 30 days out in the future so these regulations will be followed. 4) The administrator and the manager will be responsible for monitoring the corrective action. 5) 04/25/24	04/25/2024
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	0690	1) The exterior of the facility will be well maintained in the future, as required by regulation. 2) We have contacted the oxygen company, hospice agencies and the tanks have all been removed. In the future, we will contact oxygen company on a timely manner to make sure no tanks are left behind in the premises. 3) The manager and the administrator will	04/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108

(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
	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 properly stored and secured. Findings include: On 04/09/24 in the morning, the storage shed in the backyard contained 13 oxygen tanks unsecured with other items piled on top of it. On 04/09/24 in the morning, the Caregiver reported the oxygen tanks belonged to previous residents and acknowledged they were not properly stored and secured. Severity: 2 Scope: 3		check the backyard and the shed on a regular basis to make sure it is clean and well maintained, and no oxygen tanks are left behind. 4) The manager and the administrator will be responsible for monitoring this corrective action. 5) 04/25/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108

(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
0740 SS= D	Residents Requiring Indwelling Catheter - NAC 449.272 Residents requiring use of indwelling catheter. (NRS 449.0302) 1. A person who requires the use of an indwelling catheter must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is physically and mentally capable of caring for all aspects of the condition, with or without the assistance of a caregiver; (b) Irrigation of the catheter is performed in accordance with the physician ' s orders by a medical professional who has been trained to provide that care; and (c) The catheter is inserted and removed only in accordance with the orders of a physician by a medical professional who has been trained to insert and remove a catheter. Inspector Comments: Based on record review and interview, the facility failed to ensure a medical exemption request was submitted to the Bureau to retain 1 of 8 sampled residents with an indwelling catheter (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 07/18/23, with diagnosis including urinary retention. Review of R1's record revealed R1 had a Foley catheter under the care of hospice. R1's file lacked documented evidence of an application for submission and/or an approved medical exemption for a Foley Catheter from the Bureau. On 04/09/24 in the morning, R1's family member indicated R1 was confused and unable to care for the catheter on R1's own, and the hospice agency assisted. On 04/09/24 in the morning, the Administrator confirmed R1 had a Foley catheter since 06/05/23 and had not applied or been approved by the Bureau for a medical exemption for R1. Severity: 2 Scope: 1	0740	1) The medical exemption form to the Bureau has been submitted (Attachment C) When R1 was was admitted to the facility R1 was already under hospice care. R1's catheter has been cared under the hospice staff. We asked them to train us on how to empty the bag and to look for signs and symptoms of infections and etc (Attachment E). 2) The medical exemption request to the Bureau for R1 has been submitted. And for any other residents that require this form in the future, it will be submitted on time as required by regulation. 3) We will monitor all resident's condition more closely and communicate with their medical staff so these important regulations will be followed. 4) The administrator and the manager will be responsible for monitoring the corrective action. 5) 04/25/24	04/25/2024
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has	0878	1) Citation will be corrected by ensuring all medications are on site and all medications are administered per the physician's order. 2) All medications for residents will always be on site and available to be administered as required by regulation. The caregiver mistakenly informed the surveyor that R1's Hydrocodone was PRN. The physician's order states this medication to be	04/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	**1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108**

(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
	approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review, observation and interview, the facility failed to ensure: 1) medications were on site and available to be administrered		administered BID (Attachment E). This medication has been administered per the physician's order and it has been recorded on MAR (Attachment F). 3) The manager and the administrator will monitor more closely the MAR entries of staff and the medication cart to make sure missing details will not happen in the future. 4) The administrator and the manager will monitor for compliance 5) 04/25/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108

(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 2) medications were administered as prescribed for 1 of 8 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 07/18/23, with diagnosis including urinary retention. A physician's order dated 12/18/23, documented Hydrocodone 325 milligrams (mg). Take one tablet by mouth as needed for moderate to severe pain. On 04/09/24, R1's Hydrocodone was not on site and available to be administered to R1. The April 2024 Medication Administration Record (MAR) documented Hydrocodone 325 mg. Take one tablet by mouth daily. The MAR documented the medication was administered daily and was not administered per the physician's order. On 04/09/24 in the morning, the Caregiver indicated R1's order for Hydrocodone was changed from being administered every day to being administered as needed, however was unable to provide documented evidence of a discontinued order for Hydrocodone to be administered daily. The Caregiver was unaware if R1's Hydrocodone was being administered per the physician's order. The Caregiver also acknowledged the medication was not onsite and available to be administered to R1. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4409	A. BUILDING _____ B. WING _____	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108

(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
0885 SS= F	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 and interview, the facility failed to ensure medications were destroyed. Findings include: On 04/09/24 in the morning, the storage shed in the backyard contained a basket with several medications in it, a grocery bag full of medications, and a tall kitchen trash bag full of medications. On 04/09/24 in the morning, the Caregiver reported the medications belonged to previous residents who had since been discharged from the facility, and acknowledged the medications should have been destroyed and not kept in the storage shed. Severity: 2 Scope: 3	0885	1) Citation will be corrected by ensuring all medications are destroyed once they are discontinued, or residents being discharged from the facility. 2) The medications that were found in the basket had belonged to a previous residents who had since been discharged from the facility. We have corrected the citation by destroying all medications that were in the basket (Attachment G). 3) We will monitor and review all medications and MAR more strictly every 30 days to make sure they are in compliance with regulations. 4) The administrator and the manager will monitor for compliance. 5) 04/25/24	04/25/2024