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
	5061	A. BUILDING _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT OF LOVE	1213 BALZAR AVE, LAS VEGAS, NEVADA ,89106

(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 08/09/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 6 Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illnesses, and/or persons with mental illnesses, Category I residents. The census at the time of survey was six. Six resident files and five employee files were reviewed. The facility received a grade of D. 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		
0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 resident records was complete and accurate. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 07/23/23. The record for R1 lacked documented evidence of required documents including: Diagnoses; physician; medication orders; ultimate user agreement; initial activities of daily living (ADL) assessment and care required; initial physical examination; initial 2-step tuberculosis (TB) test and signs and symptoms review; cognitive level; types and amounts of protective supervision required; diet; and food and/or medication allergies. On 08/09/23 in the afternoon, Employee #2 and Employee #3 confirmed there was no record for R1 and there should have been. Severity: 2 Scope: 1	0053	0053: (1). NAC449.194 sites the Responsibilities of administrator that 0053: Administrator's Responsibilities-Complete Rec - NAC 449.194Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: Ensure that the records of the facility are complete and accurate. (1). NAC449.194 sites the Responsibilities of administrator that is regulated by (NRS449.0302). The Administrator of a residential facility shall ensure that the Resident'/and Staff records of the facility are complete and accurate (making a 2nd/copy of important documentation is an important role of the Administrator). The 2nd copy was used to replenish the residential facility file to bring file to compliance.	10/10/2023

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: CHARLENE BYNUM Title: Executive Director Date: 12/04/2023

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			(2). (R1) record/file lacked required documents such as (R1) Diagnoses; physician medication orders; ultimate user agreement; initial activities of daily living (ADL) assessment and care required; initial physical examination; and initial 2-step tuberculosis. That was provided by (R1) physician (*Diagnoses; physician's medication orders; and initial physical examination) ; (*R1) was transported *to a local medical facility for 2-step TB test; and gathered/complied initial intake forms to complete a accurate record for (R1)* *(3).To assure the listed deficiency does not reoccur/the Executive Director will make a list of needed forms and add the form to each intake packet for quick reference with an audit date, inclusive of auditing Residents and Staff files for 4/month every 25 to 30/days.* *(4). The Administrator and Executive Director; shall maintain the responsibility for ensuring that each Plan of Correction shall be implemented.* *(5).The corrections were completed (10/10/2023).* *(6).See attachment of supporting documents.* *(7). Observation/Monitoring Behaviors and asking Questions describes how providers will identify any potential affected wellness (mental, Physical, emotional issues may have been caused by Administrator lack of being Responsible/and being Compliance as authorized (in* NAC449.194).	

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0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the	0074	*0074.* *(1).* E3's last Elder Abuse training was missing from file; and was corrected by putting a copy of the Elder Abuse Training in the record/file. Making a 2nd/copy of trainings is an important role of the Administrator; that should be maintained in a Administrative Facility File.The2nd copy was used to replenish the residential facility file to bring residential file to compliance. (2). (E3) record/file lacked the required document (Elder Abuse Training) The Executive Director require staff to turn in a copy of each training after trainings are finished/for their Administrative Employee's file: So, a copy of the missing Training was transported to the residential facility put in the E#3 file. (3). *To assure the listed deficiency does not reoccur/the Executive Director will make a list of needed forms and add the form to each intake packets for quick reference with file audit date, inclusive of auditing files for 4/months every 25 to 30/days.* (4*). The Administrator and Executive Director; shall maintain the responsibility for ensuring that each Plan of Correction shall be implemented; and decrease Caregivers access to Employee Facility files.* *(5). The corrections were completed (10/11/2023).*	10/11/2023

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	care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that		*(6). See attachment of supporting documents.* *(7). Observation/Monitoring Behaviors and asking Questions describes how providers will identify any potential affected wellness (mental,* *physical, or emotional issues that may have been caused by Administrator lack of being Responsible/and being Compliance as* *authorized (in* NAC449.194) .	

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	each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 employees had annual elder abuse training. (Employee #3) Findings include: Employee #3 (E3) E3 had a hire date of 03/10/20 as a Caregiver. E3's last elder abuse training was on 04/12/22. E3's record lacked documented evidence of annual elder abuse training. On 08/09/23 in the afternoon, E3 confirmed the missing annual elder abuse training for E3, and had been providing services to the residents since their hire date. Severity: 2 Scope: 1			
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 employees had a two-step or annual tuberculosis (TB) test. (Employee #5) Findings include: Employee #5 (E5) E5 had a hire date of 2010 as the Administrator. E5 had an annual TB test with a final read date of 09/30/21 and a negative result. E5's record lacked documented evidence of an annual TB test. On 08/09/23 in the afternoon, E2 confirmed there was no annual TB test for E5. Severity: 2 Scope: 1 This was a repeat deficiency from the 07/05/22 annual State Licensure survey.	0102	*0102* Personnel File - TB Screening - NAC 449.200 Personnel files *(1).1 of 5 employees record is currently compliance with the* *regulation an annual two-step tuberculosis TB) test. (Employee* #5) findings included: Employee #5 (E5) E5 had a hire date of 2010 as the Administrator/and record indicated a final reading date of 09/30/21 with a negative result. The Executive Director require staff to turn in a copy of each training after trainings are finished/for their Administrative Employee's file (a	10/11/2023

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			copy of the training was transported to facility and put in E'5 file). *(2). To assure the listed deficiencies does not reoccur/the following* *systematic change shall be put in place: 2a. The* *Executive Director will take responsible for putting* *the training in the Employee file, inclusive of 2b. Auditing files for* *4/month every 25 to 30/days.* *(3). To assure the listed deficiency does not reoccur the* *Executive Director will make a list of needed intake forms and add the form to* *each intake packets for quick reference/and audit file every for* *4/months every 25 to 30/days; and* *decrease the number of Caregivers that have access to employee files.* *(4). The Administrator and Executive Director;* *shall maintain the responsibility for ensuring that each Plan* *of Correction shall be implemented.* *(5). The corrections were completed (10/11/2023).* *(6). See attachment of supporting*	

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			documents. *(7). Observation/Monitoring Behaviors and asking Questions describes* *how providers will identify any potential affected wellness* *(mental, physical or emotional* *issues may have been caused by Administrator lack of being* *Responsible/and being Compliance as authorized (in NAC449.200).*	
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 5 employees met the requirements for first aid and cardiopulmonary resuscitation (CPR) training. (Employee #1, #2, #3 and #4) Findings include: Employee #1 (E1) E1 had a hire date of 2015, as the Administrator. E1's record documented the last first aid training was on 05/22/21. E1's record lacked documented evidence of current first aid training. Employee #2 (E2) E2 had a hire date of 05/01/17, as a Caregiver. E2's record documented the last first aid training was on 05/22/21. E2's record lacked documented evidence of current first aid training. Employee #3 (E3) E3 had a hire date of 03/10/20, as a Caregiver. E3's record documented current CPR training on 04/07/22. E3's record documented the last first aid training was on 05/22/21. E3's record lacked documented evidence of current first aid training. Employee #4 (E4)	0106	***0106*** *(1). Each of the* 4 of 5 employees currently are compliance with the requirements for First Aid and Cardiopulmonary Resuscitation (CPR)training (Employee #1, #2, #3 and #4). Findings included: Employee#1 (E1) E1 had a hire date of 2015, as the Assistant to the Administrator. E1's record indicated the last first aid training was on 05/22/21 (current CPR/and 1stAid Training 04/04/2022- 04/04/2024). Employee #2 (E2) E2 was hired 05/01/17; E2's record lacked documented evidence of current first aid training (currently compliance- 10/12/23 - 10/12/2025). Employee #3 (E3)	10/13/2023

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	E4 had a hire date of 07/10/23, as a Caregiver. E4's record lacked documented evidence of current first aid/CPR training. On 08/09/23 in the afternoon, E3 confirmed E3 did not have current first aid training. E2 also confirmed the missing first aid training for E1, E2 and E3 and that E4 had not completed the initial first aid and CPR training. Severity: 2 Scope: 3		had a hire date of 03/10/20; record reflected most current CPR training was on 04/07/22/ and the last first aid training was on 05/22/21 while Caregiver remained employed (currently E#3 is compliance with first aid/and CPR training (10/12/2023- 10/12/2025). Making a 2nd/copy of trainings is an important role of the Administrator; that should be maintained in a Administrative Facility File. The 2nd copy was used to replenish the residential facility file to bring residential files to compliance. Employee #4 had a hire date of 07/10/23, as a Caregiver (had to take a CPR & First Aid Training) to support compliance. E4's record lacked documented evidence of current first aid/CPR training. E1, E2 and E3 and E4 files have been updated with current first aid/and CPR training. (2). To *assure the listed deficiency does not reoccur/the* *Executive Director will take responsible for putting* *the training in the Employee file, inclusive of auditing*	

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			files for 4/months every 25 to 30/days. (3). To *assure* the deficiency *does not reoccur/the* *Executive Director will make a list of needed forms and add the form to* *each intake packet, inclusive of auditing* *files for 4/months every 25 to 30/days; and also decrease the number of Caregivers* *that are allowed* *to have a key to facility files.* *(4). The Administrator and Executive Director;* *shall maintain the responsibility for ensuring that each Plan* *of Correction shall be implemented.* *(5). The corrections were completed (10/13/2023).* *(6). See attachment/s of supporting documents.* *(7). Observation/Monitoring Behaviors and asking Questions describes* *how Providers will identify any potential affected wellness* *(mental, physical, or emotional* *issues that may have been caused by Administrator lack of being*	

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			Responsible/and being Compliance as authorized (in NAC449.200).	
0532 SS= C	Activities for Residents - NAC 449.260 Activities for residents. (NRS 449.0302) 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 1 month in advance; and (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 ensure a current Activity Calendar was posted. Findings include: On 08/09/23 in the morning, observed a July 2023 Activity Calendar posted on the wall. There was no Activity Calendar for August 2023 posted. On 08/09/23 in the morning, Employee #3 confirmed there was no Activity Calendar posted for August 2023 and that there should have been one posted. Severity: 1 Scope: 3	0532	0532 In accordance to HCQC/and Residentials' Physicians in promoting health, requires mental, physical and emotional well-being. Which requires the Facility Administrator to ensure a current Activity Calendar is posted on the wall of the Facility. Findings include: On 08/09/23 in the morning, observed a July 2023 Activity Calendar posted on the wall; but No August Activity Calendar. To bring the Facility to compliance a August, September, October, November, and December for 2023 Activity Calendar was created. (2). To *assure the listed* deficiency *does not reoccur/the* *Executive Director will take responsible for observing the current*	10/20/2023

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			Activity Calendar *inclusive of auditing* *files for 4/months every 25 to 30/days.* (3). To *assure* the deficiency *does not reoccur/the* *Executive Director will make a list of needed forms and add the form to* *each intake packet, inclusive of auditing* *files for 4/months every 25 to 30/days also checking the Activity* *Calendar to assure each month is created at least 30/days prior to* *each month with the number of hours weekly on the calendar.* *(4). The Administrator and Executive Director;* *shall maintain the responsibility for ensuring that each Plan* *of Correction shall be implemented.* *(5). The corrections were completed (10/20/2023).* *(6). See attachment/s of supporting documents.* *(7). Observation/Monitoring Behaviors and asking Questions describes*	

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			how Providers will identify any potential affected wellness *(mental, physical, or emotional* *issues that may have been caused by Administrator lack of being* *Responsible/and being Compliance as authorized (in NAC449.200).*	
0840 SS= D	Review of Medical Condition of Resident - NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.0302) 1. If, after conducting an inspection or investigation of a residential facility, the Bureau determines that it is necessary to review the medical condition of a resident, the Bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the Bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the Bureau, provide to the Bureau: (a) The assessments made by physicians concerning the physical and mental condition of the resident; and (b) Copies of prescriptions for medication or orders of physicians for services or equipment necessary to provide care for the resident. Inspector Comments: Based on observation, record review and interview, the Bureau of Health Care Quality and Compliance (HCQC) determined a review by a physician of the physical and mental condition of 1 of 6 residents was necessary. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 07/23/23. On 08/09/23 in the morning, there was no documented evidence of a resident file for R1, including diagnoses and physician orders for medications. On 08/09/23 in the afternoon, the surveyor observed the	0840	0840: Review of Medical Condition of Resident - NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.0302). (1). There was no documented evidence of Resident in the file for R1, that included diagnoses and physician orders for medications. The deficiency was corrected by calling R#1 doctor/ requested evident of medical and mental conditions and a list of medications (documentation picked-upby Executive Director and put in R#1 file). (2). To *assure the listed deficiency does not reoccur/the*	10/17/2023

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	5061	A. BUILDING _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT OF LOVE	1213 BALZAR AVE, LAS VEGAS, NEVADA ,89106

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	following medications in a bin labeled with R1's name: -Risperidone 3 milligrams (mg), 1 tablet twice daily for mood and hallucinations -Levothyroxine 25 micrograms (mcg), 1 tablet daily -Benztropine 0.5 mg, 1 tablet twice daily -Metformin Extended Release (ER) 500 mg, 1 tablet twice daily -Haloperidol 2 mg, 1 tablet at bedtime for auditory and visual hallucinations -Loratadine 10 mg, 1 tablet daily -Atorvastatin 20 mg, 1 tablet at bedtime -Escitalopram 20 mg, 1 tablet daily -Fluticasone 50 mcg, 2 sprays in each nostril daily On 08/09/23, the surveyor observed R1 throughout the day. R1 responded to surveyor questions with basic responses and was observed moving quietly between the living room and R1's bedroom. On 08/09/23 in the afternoon, Employee #2 and Employee #3 confirmed there was no resident file for R1 and no physician orders. Employee #3 confirmed E3 administered medications to R1 since R1's admission to the facility. On 08/09/23 at 5:00 PM, the surveyor requested a full list of physician orders for R1 no later than 9:00 AM on 08/10/23. An email sent was on 08/10/23 at 6:44 AM to the Executive Director and Employee #2, with a reminder to submit the physician orders for R1. The information was not presented to the surveyor. On 08/09/23 at 5:00 PM, the surveyor from HCQC determined a review by a physician of R1's physical and mental condition was necessary due to the resident was being administered multiple medications, including antipsychotic medication, with no documentation of R1's diagnoses or physician orders. Severity: 2 Scope: 1		*Executive Director will take responsible for putting documentation in the Residents' files, inclusive of auditing files for 4/months every 25 to 30/days.* *(3). To assure the deficiency does not reoccur/the Executive Director will* *make a list of needed forms and add the Administrative* *forms to* *each intake packet, inclusive of auditing* *files for 4/months every 25 to 30/days; and also decrease the number of* *Caregivers that are allowed to have a key to facility files.* *(4). The Administrator and Executive Director;* *shall maintain the responsibility for ensuring that each Plan* *of Correction shall be implemented.* *(5). The corrections were completed (08/10/2023; and updated on 10/17/2023).* *(6). See attachment/s of supporting documents.* *(7). Observation/Monitoring Behaviors and asking Questions describes how* *Providers will identify any potential affected wellness* *(mental, physical, or emotional).*	

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0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on observation, record review and interview, the facility failed to document an injury for 1 of 6 residents. (Resident #4) Findings include: Resident #4 (R4) R4 was admitted on 03/02/18, with primary diagnoses including diabetes, bipolar disorder, anxiety, hypertension and depression. On 08/09/23 in the morning, R4 was observed with bandaging on the right arm from the hand to the elbow. The bandaging appeared clean. On 08/09/23 in the morning, R4 reported in July 2023, R4 was coming back to the facility from an ice cream truck on the street in front of the facility and tripped and fell in the driveway. R4 described R4's ring and pinky finger on the right hand was injured and bandaged. R4 could not provide the date of the injury or who was providing care for the injury. On 08/09/23 in the morning, there was a lack of documented evidence of an incident report of R4's injury, to include the date, time, description of how the injury occurred and employee response to the injury. Employee #2 and Employee #3 confirmed there was no documented incident report for R4's injury and could not provide details on the injury. Severity: 2	0853	0853 Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident. (1). R4 was admitted on 03/02/18, with primary diagnoses including diabetes, bipolar disorder, anxiety, hypertension and depression. On 08/09/23 the State Surveyor observed R#4 was wearing a bandage on the right arm from the hand to the elbow whereas the State Surveyor reported that the bandage appeared clean. The deficiency was corrected by printing a copy of the incident report from the Administrative Office Computer; and requesting a copy of the reported injury State Case Manger (which was emailed to facility Executive Director).	10/20/2023

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	Scope: 1		(2). The *Executive Director will assure the deficiency does not reoccur by immediately making a written incident after getting clear details and collecting evidence that Caregiver reported. Thereafter the Executive Director shall immediately put a copy of incident report into the Resident file.* (3). The *Executive Director will assure the deficiency does not reoccur by immediately putting a copy of incident report into the Resident file inclusive of auditing* *files for 4/months every 25 to 30/days; and also decrease the number of Caregivers that are allowed to have a key to facility files to assure* *documentation has not been removed.* *(4). The Administrator and Executive Director; shall maintain the responsibility for ensuring that each Plan of Correction shall be implemented to decrease the likelihood of deficiency reoccurring.* *(5). The corrections were completed (10/20/2023).* *(6). See attachment/s of supporting documents.* *(7).Observation/Monitoring Behaviors and asking Questions describes how Providers will identify any potential affected wellness* *(mental, physical, or emotional).*	

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure an initial physical examination was completed for 1 of 6 residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 07/23/23. R1's record lacked documented evidence of an initial physical examination. On 08/09/23 in the afternoon, Employee #2 confirmed the missing initial physical examination. Severity: 2 Scope: 1 This was a repeat deficiency from the 07/05/22 annual State Licensure survey.	0859	0859: (1). Making a 2nd copy of important documentation is an important role of the Administrator; and keeping Residents' doctors contact information as a quick reference; and building a rapport with doctors office staff. The 2nd copy was used to replenish the residential facility file to bring file to compliance. (2). (R1) record/file lacked required documents such as (R1) Diagnoses; physician medication orders; ultimate user agreement; initial activities of daily living (ADL) assessment and care required; initial physical examination; and initial 2-step tuberculosis. That was provided by (R1) physician (*Diagnoses;* *physician's medication orders; and initial physical*	10/19/2023

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			examination);(R1) was transported *to a local medical facility* *for 2-step TB test; and gathered/complied initial intake forms* *to complete a accurate record for (R1).* *(3). To assure the listed deficiency does not reoccur/the* *Executive Director will make a list of needed forms and add the form to* *each intake packet for quick reference with an audit date, inclusive of auditing* *Residents and Staff files for 4/months every 25 to 30/days.* *(4). The Administrator and Executive Director;* *shall maintain the responsibility for ensuring that each Plan* *of Correction shall be implemented.* *(5).The corrections were completed (10/19/2023).* *(6).See attachment of supporting documents.* *(7).Observation/Monitoring Behaviors and asking Questions describes* *how providers will identify any potential affected wellness* *(mental, Physical, emotional)* *issues may have been caused by Administrator lack of being* *Responsible/and being Compliance as authorized (in* NAC449.194).	

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0895 SS= F	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, record review and interview, the Administrator failed to ensure the Medication Administration Record (MAR) was accurate for 3 of 6 residents. (Resident #1, #2 and #5) Findings include: Resident #1 (R1) R1 was admitted on 07/23/23. On 08/09/23 in the afternoon, observed the following MAR inaccuracies: -A medication bottle of Risperidone 3 milligrams (mg) read take 1 tablet twice daily. The August 2023 MAR listed the medication as 1 tablet twice daily at bedtime, with only one administration line signed by R1 and Employee #3 documenting the medication administration only at 8:00 PM. On 08/09/23 at 2:20 PM, Employee #3 acknowledged the discrepancy only R1's MAR and reported they read the bottle and not the MAR, and the medication had been administered to R1 twice daily. -A medication bottle of Levothyroxine 25 micrograms (mcg), take 1 tablet daily was signed on the MAR as administering 25 milligrams (mg) daily. Employee #3 confirmed the discrepancy, confirming the MAR should have read 25 mcg. Resident #2 (R2) R2 was admitted on 04/16/21, with primary diagnoses including diabetes, irregular heart beat and chronic kidney disease stage III. On 08/09/23 in the afternoon, R2's MAR reflected the following inaccuracies: -A medication label	0895	0895: Administration of Medication Maintenance - NAC 449.2744 **(1). The MARs were corrected by drawing a line through the mistake and writing the word ('ERROR') making the correction and circling the initials/and checking MARs for missing/or incorrect information.** **(2). To *assure the* deficiency *does not reoccur/the*** **Corrective action shall be monitored by Executive Director/by signing Name as the Responsible Provider on the 1stof each month when signing being the Provider on the Medication Mars; inclusive of at least twice a week/for 4 months monitor Caregivers administrate medications and check medication labels against Mars assuring MARs are correct.** **(3). To** *assure the listed deficiency does not reoccur/the* ***Executive Director will take responsible for monitoring Caregiver/s Medication Administration and the Medication Mars for 4/months at least twice a week.*** ***(4). The Administrator and Executive Director; shall maintain the responsibility***	10/20/2023

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	documented TechLITS Pen Needles 8 millimeters (mm) - 31 grams, was not listed on the July 2023 or August 2023 MAR. Employee #3 acknowledged the medication was not listed on the July and August 2023 MAR. -A medication label documented AutoShield DUO 0.30 mm x 5 meters Sterile Insulin Needles, was not listed on the August 2023 MAR. Employee #3 acknowledged the medication was not listed on the August 2023 MAR and reported the medication order had changed. There was no documented evidence the order for the use of these insulin needles had changed. - A medication bottle of Saline Mist 0.65% Nose Spray, not listed on the August 2023 MAR. Employee #3 acknowledged the medication was not listed on the August 2023 MAR and reported R2 was not using the medication. Employee #3 acknowledged not obtaining a discontinue order for the Nose Spray. Resident #5 (R5) R5 was admitted on 03/02/18, with primary diagnoses including bipolar disorder, schizoaffective disorder, obesity, hypertension and depression. On 08/09/23 in the afternoon, R5's MAR documented Atorvastatin 40 mg, take 1 tablet at bedtime, was listed on the MAR twice for August 2023, and was signed as administered twice every night between 08/01/23 and 08/08/23. On 08/09/23 in the afternoon, Employee #2 and Employee #3 confirmed the Atorvastatin was listed twice on the August 2023 MAR in error. Employee #3 reported writing the medication on the MAR twice, but reported the medication was only administered to R5 once nightly between 08/01/23 and 08/08/23. Severity: 2 Scope: 3		*for ensuring that each Plan of Correction shall be implemented.* *(5). The corrections were completed (10/20/2023.* *(6). See attachment/s of supporting documents.* *(7). Observation/Monitoring Behaviors and asking Questions describes how Providers will identify any potential affected wellness (mental, physical, or emotional-------- None has occurred).*	
0923 SS= E	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered.	0923	0923 (1). Medications are currently kept in their original bottle/ Medication, including, without limitation, any over-the-counter medication or dietary supplement, has been Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and kept in its original container until it is administered. (2). No medication will be mixed with	09/02/2023

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	Inspector Comments: Based on observation and interview, the facility failed to ensure medications were kept in their original container for 1 of 6 residents (Resident #1) and failed to ensure a medication was properly labeled for 1 of 6 residents. (Resident #2) Findings include: Resident #1 (R1) On 08/09/23 at 2:30 PM, observed the following medications not kept in their original container: -A bottle of Risperidone 3 milligrams (mg), 1 tablet twice daily. The bottle contained two different shapes and color of pills in it, one was round and yellow and the other one was small and white. The small white pills could not be identified. The bottle was marked filled on 06/07/23 with 180 pills. Upon an employee count on 08/09/23 at 2:55 PM, the pill count in the bottle was 174 round yellow pills and 13 small white pills. -A bottle of Metformin Extended Release 500 mg, 1 tablet twice daily, marked filled on 06/09/23 with 66 pills. Upon an employee count on 08/09/23 in the afternoon, there were 57 1/2 pills in the bottle. - A bottle of Levothyroxine 25 micrograms (mcg), 1 tablet daily, marked filled on 05/30/23 with 90 pills. Upon an employee count on 08/09/23 in the afternoon, there were 100 pills in the bottle. - A bottle of Haloperidol 2 mg, 1 tablet at bedtime, marked filled on 05/12/23 with 90 pills. Upon an employee count on 08/09/23 in the afternoon, there were 74 pills in the bottle. - A bottle of Loratadine 10 mg, 1 tablet daily, marked filled on 10/14/22 with 90 pills. Upon an employee count on 08/09/23 in the afternoon, there were 50 pills in the bottle. -A bottle of Atorvastatin 20 mg, 1 tablet at bedtime, marked filled on 06/09/23 with 100 pills. Upon an employee count on 08/09/23 in the afternoon, there were 84 pills in the bottle. - A bottle of Escitalopram 20 mg, 1 tablet daily, was marked filled on 05/31/23 with 90 pills. Upon an employee count on 08/09/23 in the afternoon, there were 72 pills in the bottle. On 08/09/23 in the afternoon, Employee #3 reported being unaware of why R1 had an excess number of pills in each of R1's medication bottles, conflicting with how many pills were dispensed, and that R1's medications were combined into one respective bottle at the time of admission.		another medication (over-the-counter medication or dietary supplement and prescribed medication). Each medication will remain in it original bottle/or container (labeled with Resident Name, prescribing physician; ----------and in its original container until it is administered). (3). To *assurethe listed deficiencydoesnot reoccur/the* ***Executive Director will take responsible for monitoring Caregiver/s Medication Administration and the Medication MARs for 4/months at least twice a week.*** ***. (4).The Administrator and Executive Director; shall maintain the responsibility for ensuring that each Plan of Correction shall be implemented.*** ***(5). The corrections were completed (09/02/2023.*** ***(6). See attachment/s of supporting documents.*** ***(7).). Observation/MonitoringBehaviors and asking Questions describes how*** ***Providers will identify any potential affected wellness (mental, physical, or emotional ------ none identified or reported).***	

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	On 08/09/23 at 3:00 PM, the Caregiver from the transferring facility reported giving all medications to R1 at the time of discharge and when R1 was admitted to the new facility, all previously ordered and currently ordered medication bottles on hand were combined into one. The Caregiver could not identify the unidentified medication in the Risperidone bottle. Resident #2 (R2) On 08/09/23 in the afternoon, the surveyor observed AutoShield DUO 0.30 millimeters (mm) x 5 meters Sterile Insulin Needles - 9 in a plastic bag with no resident name on the package or on the plastic bag. The needles were in R2's medication bag. On 08/09/23 in the afternoon, Employee #3 confirmed the insulin needles belonged to R2, there was no name on the plastic bag containing the insulin needles and R2's name should have been on the bag. Severity: 2 Scope: 2			
0936 SS= D	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 record review and interview, the facility failed to ensure 1 of 6 residents met the requirements for an annual tuberculosis (TB) test. (Resident #6) Findings include: Resident #6 (R6) R6 was admitted on 12/13/21. R6's file documented an annual TB test with a read date of 05/27/22 and a negative result. R6's file lacked documented evidence of a 2023 annual TB test. On 08/09/23 in the afternoon, E2 confirmed the missing annual TB test for R6 and that there should have been an annual test	0936	0936: (1). A separate file shall be maintained for each resident of facility and retained for at least 5 years after he or she discharges/or leaves the facility. The file shall be kept locked in fire resistant file/and protected against unauthorized use (and contain each form of the record). (2).To *assure the listed deficiency does not reoccur/the* ***Executive Director will take responsible for auditing Residents Files for4/months every 25 to/30-day; and document in the files the next date for the*** ***annual TB test, which is inclusive of a plan for Resident TB testing will be scheduled the 1st. business day after admit.*** ***(3).To assure the deficiency does not reoccur/the***	10/20/2023

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	completed. Severity: 2 Scope: 1 This deficiency is a repeat from the 07/05/22 annual State Licensure survey.		***Executive Director shall* audit files for 4/months every 25 to/30-day; and write the scheduled date on a calendar that will hang over the Medication Desk in *visible* sight; and put the scheduled date to be tested in the Executive Director phone *scheduler.*** ***(4).The Administrator and Executive Director;*** ***shall maintain the responsibility for ensuring that each Plan*** ***of Correction shall be implemented.*** ***(5).The corrections were completed (10/20/2023.*** ***(6).See attachment/s of supporting documents.*** ***(7).Observation/Monitoring Behaviors and asking Questions describes how Providers will identify any potential affected wellness (mental, physical, emotional -----*** ***None has been identified/or reported).***	
1305 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not	1305	1305: (1). A Non-Discrimination statement has been posted for residents and/public to view. The A Non-Discrimination statement was uncovered from other posted statements (currently visually). (2). To *assure the listed deficiency does not reoccur/the* ***Executive Director will take responsible for monitoring Walls for assuring no Documents are covering other documents for 4/months at least twice a week.*** ***(3).To***	08/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5061	A. BUILDING _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT OF LOVE	1213 BALZAR AVE, LAS VEGAS, NEVADA ,89106

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	permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. Inspector Comments: Based on observation and interview, the facility failed to ensure a current non-discrimination statement was posted prominently in the facility. Findings include: On 08/09/23 in the morning, the facility lacked a current non-discrimination statement for residents and the public to view. On 08/09/23 in the afternoon, the Employee #2 acknowledged a current non-discrimination statement was not posted prominently in the facility. Severity: 1 Scope: 3		***assure the deficiency does not reoccur/the Executive Director shall monitor Wall Postings (Activity Calendar/and Non-*** ***Discrimination Statement); monitoring will take place at least twice a week for the next 4/months; and shall be the only person posting wall statements .*** ***(4).The Administrator and Executive Director; shall maintain the responsibility for ensuring that each Plan of Correction shall be implemented.*** ***(5).The corrections were completed (08/10/2023).*** ***(6).See attachment/s of supporting documents.*** ***(7).Observation/Monitoring Behaviors and asking Questions describes how Providers will*** ***identify any potential affected wellness (mental, physical, or emotional--- None --------*** ***identified or reported).***	
1540 SS= D	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and	1540	1540: 1. Thisprovider has officially put E # in a secured file (locked in file cabinet); 1).There was no documented evidence of a Culture Compliancy Training in	10/18/2023

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	5061	A. BUILDING _____ B. WING _____	08/09/2023

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	at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees were in compliance with Nevada Revised Statutes (NRS) 449.103, regarding initial cultural competency training. (Employee #4) Findings include: Employee #4 (E4) E4 was hired on 07/10/23 as a Caregiver. E4's file lacked documented evidence of initial cultural competency training. On 08/09/23 in the afternoon, Employee #2 acknowledged E4's file lacked documented evidence of initial cultural competency training. Severity: 2 Scope: 1		the Employees file. The Executive Director made a 2nd copy from the Administrative Office to bring employee's file to compliance. (2).To *assure the listed deficiency does not reoccur/the* ***Executive Director shall note that each required Training has be put in employee file and not kept personally.*** ***(3).To assure the** deficiency **does not reoccur/the*** ***Executive Director shall develop policies for new employees and have employee to sign policy about trainings; files shall be monitored for 4 months every 25 to 30 days.*** ***(4).TheAdministrator and Executive Director;*** ***shallmaintain the responsibility for ensuring that each Plan*** ***ofCorrection shall be implemented.*** ***(5).The** correctionswere completed (10/18 /2023).* ***(6).See** attachment/sof supporting documents.* ***(7).Observation/Monitoring Behaviors and asking Questions describes how Providers will identify any potential affected wellness*** ***(mental; physical, or emotional).***	
1600 SS= C	Preferred Name/Pronoun P& P - R016-20 Section 19.1 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper	1600	1600: Preferred Name/Pronoun P& P - R016-20 Section 19.1 1. (1). There was no documented evidence of a Culture Compliancy policy in the	10/18/2023

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	records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. 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 gender identity or expression and preferred name; and R016-20 Section 20, regarding reasonable accommodations in providing statements and information to residents unable to read and/or speak English, are blind or visually impaired or have communication impairments. Findings include: A review of residents records for #1, #2, #3, #4, #5 and #6, documented no revisions to the records to reflect gender identity or expression and preferred name. The facility had no revised policies to be in compliance with R016-20 Section 19 and R016-20 Section 20. On 08/09/23 in the afternoon, Employee #2 confirmed there were no updated policies or changes to resident records to reflect the new regulations. Severity: 1 Scope: 3		Compliance Book. The Executive Director created Culture Compliance Policy (and put a copy in the Facility the Compliance Book). (2).To *assure the listed deficiency does not reoccur/the* ***ExecutiveDirector shall note that each required Training has a significant of a created Policy.*** ***(3).To assure the deficiency does not reoccur/the*** ***Executive Director shall develop policies of most new trainings; and monitor compliance book for any missing policies/for 4/months every 25 to 30/days; and also document in each residents' and employees' preferred pronoun in their file/record.*** ***(4).The Administrator and Executive Director;*** ***shall maintain the responsibility for ensuring that each Plan*** ***of Correction shall be implemented.*** ***(5). The corrections were completed*** *(12/04/2023).* ***(6). See attachment/s of supporting documents.*** ***(7).Observation/Monitoring Behaviors and asking Questions describes how Providers will identify any potential affected wellness*** *(mental, physical, or emotional).*	