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
	5432	A. BUILDING _____ B. WING _____	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW CONNECTIONS GROUP CARE HOME	**820 ANTIGUA ST, LAS VEGAS, NEVADA ,89145**

(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 and infection control survey conducted in your facility on 09/01/21. This State Licensure survey was conducted in accordance with NAC 449, Residential Facilities for Groups. The facility is licensed for six Residential Facility for Group beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files and three 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 antidiscrimination 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. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ROSVI ALBEZA Title: Administrator Date: 09/12/2021

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0106 SS= D	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 interview and record review, the facility failed to ensure 1 of 3 employees had a current cardiopulmonary resuscitation (CPR) certification (Employee #3 - CPR expired 05/16/21). The Administrator was unable to provide documentation of current CPR certification. Severity: 2 Scope: 1	0106	1. The staff was immediately sent to training to renew her CPR and First Aid certification. (copy of the card was attached) 2.We will put a reminder on the facility reminder board for those staff that needs to go to training for renewal and send them to training in advance prior to expiration. 3. We will do a periodic routine review of all the files of the staff to avoid lapses in required trainings for compliance. 4. The RFA will review and monitor the CPR and 1st aid files of the staff. 5. The CPR and 1st aid training renewal was accomplished 9/5/2021 6. The copy of the CPR and First Aid card was uploaded for review. 7. The facility will do a periodic routine review of the all the staff and residents files for compliance.	09/05/2021