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 _____	**07/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EUROPEAN HOME CARE	**3212 EL CAMINO RD, LAS VEGAS, NEVADA ,89146**

(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 a complaint investigation initiated at your facility on 07/28/22 and completed on 09/07/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 8. The facility received a grade of A. There was one complaint investigated. Complaint #NV00066724 with one allegation was substantiated. The allegation the facility failed to contact the physician and/or 911 in a timely manner for a resident (Resident #1) who wandered back and forth from inside to outside, in the heat was substantiated. (See Tag Y0850) 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 deficiency was identified:	0000		
0850 SS= G	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) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on observation, interview, and record review, the facility failed to contact the physician	0850	**1)** Reinforced and targeted training on ambulatory Alzheimer's residents who have a tendency to wander, will be the initial correction for the finding stated in the SOD. This will include all staff trained on an updated Wandering Manual that specifically addresses this deficiency (**see attached updated Wandering Manual including the acknowledgement of training**). We have also added to this Wandering training update a technical bulletin from DPBH from June of 2014 addressing excessive heat in Summer and have outlined specifically the regulations for seeking medical assistance when a resident exhibits any signs of distress. **2)** Our orientation and initial Alzheimer training will place a greater emphasis on the Wandering aspect and the need for continually knowing where all residents are	09/27/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CRESENCIA C SMITH Title: Administrator Date: 10/02/2022

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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	and/or 911 in a timely manner for a resident (Resident #1) who wandered back and forth from inside to outside, in the heat. Findings include: Resident #1 (R1) R1 was admitted on 08/21/20, with diagnoses including Alzheimer's disease, and hypertension. Review of R1's file revealed an incident report dated 07/17/22 which documented at around 1:00 PM, R1 became restless and began repeatedly going into the backyard gate and attempting to exit the facility. Employee #2 (E2) attempted to redirect R1 indoors, but R1 continued to go into the backyard. At 10:30 PM, Emergency Medical Services (EMS) was contacted. When EMS paramedics arrived, the paramedics assessed R1 and determined R1 required transportation to the Emergency Room (ER). A review of the National Weather Service listed the high temperature as 108*Fahrenheit (F) on 07/17/22. On 07/28/22 at 1:30 PM, Employee #2 (E2) indicated on 07/17/22, R1's behavior had become increasingly agitated and R1's desire to enter the backyard and attempt to repeatedly exit the facility had increased. R1 became increasingly convinced a family member would be picking R1 up from the facility to bring R1 home. E2 revealed when R1 began the exit-seeking behavior, E2 attempted to redirect R1 indoors through various methods and R1 continued to go outside. At 7:00 PM, R1 showed signs of heat exhaustion (fatigue and high body temperature) and was brought inside, where E2 and other Caregivers attempted to hydrate and cool R1. R1 was unable to be hydrated and cooled, so E2 contacted EMS at 10:30 PM. R1's file lacked documented evidence the facility contacted R1's physician, to notify the physician of R1's continuous exit seeking behaviors and signs of heat exhaustion, including fatigue, increased confusion, and a high body temperature. Review of hospital records indicated R1 was admitted to the ER on 07/17/22. The EMS paramedics estimated the resident was outside for over an hour.		at all times. Although this has always been the policy, continual reinforcement will be the key. Adding these wandering safeguards to the annual 8-hour Caregiver Training will also be essential. We have attached an Incident/Accident Report which will be completed in a situation such as the deficiency noted in this complaint investigation. We have revised this form to require addressing the need for an immediate medical intervention in extreme cases (**see Incident/Accident form attached**). **3)** These POC changes will be monitored by continual reinforcement from Management, as well as further targeted initial and general on-going training. A better communication among caregivers with those Resident's needing Protective Supervision, will also be implemented. (**see attached Protective Supervision form**). **4)** The day-to-day Manager will be responsible for initial implementation. **5)** September 30, 2022	

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	R1 presented with heat stroke, dehydration, and hyperthermia. Cooling measures were initiated my ER staff and R1 remained in the ER for twenty-four hours for observation. On 09/07/22, a telephone interview with E2 revealed R1's physician was not contacted regarding R1's increased agitation, exit-seeking behaviors, signs of heat exhaustion including fatigue, increased confusion, and a high body temperature the day of the incident on 07/17/22. Severity: 3 Scope: 1 Complaint #NV00066724			