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 |
|---|---|---|---|
| | 6035 | A. BUILDING _____ B. WING _____ | 12/12/2023 |

| 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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey completed at your facility on 12/12/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten beds for elderly and disabled and/or persons with chronic illness and/or persons with Alzheimer's disease, Category II residents. The census at the time of survey was nine. Nine resident files and six employee files were reviewed. The facility received a grade of A. 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 | | |
| 0250 SS= D | Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure the kitchen was properly cleaned and sanitized. Findings include: On 12/12/23 in the morning, food debris and excess grease was found in two ovens and the top of the refrigerator contained large amounts of dust. On 12/12/23 in the morning, the Owner confirmed the kitchen needed to be cleaned including the top of the refrigerator and two ovens. Severity: 2 Scope: 1 | 0250 | 1) We have corrected the specific findings by cleaning the kitchen oven and entire area during the Inspection process.<br>2) We have directed the cooks to make sure the kitchen area is cleaned before the end of their shifts to include floors, garbage removal, dishes washed and put away, inside oven, microwave and burners, counter tops sanitized, cupboards organized, and dining room table set for the next meal.<br>3) The owner/manager will inspect each day to verify policy is followed, along with the Administrator at least weekly. Constant eyes on the problem will ensure the deficient practice will not recur.<br>4) Owner/Manager will be responsible for seeing this plan is implemented and followed.<br>5) 12/12/2023 | 12/12/2023 |

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: CRESENCIA C. SMITH | Title: Administrator | Date: 12/26/2023 |
|---|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 6035 | A. BUILDING _____ B. WING _____ | 12/12/2023 |

| 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 |
|---|---|---|---|---|
| 0995 SS= F | Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure the main road was not able to be accessed by the residents from the back yard area and a gate leading to the main road was properly locked and secured. Findings include: On 12/12/23 in the morning, a gate on the right side of the home, separating the back yard from the front yard and main road, was found unlocked. On 12/12/23 in the morning, the Owner confirmed the facility was endorsed to admit residents with Alzheimer's and dementia related diagnoses. The Owner confirmed the gate on the right side of the home was unlocked. Severity: 2 Scope: 3 | 0995 | 1) We have corrected the finding by locking the gate during the inspection process. We will change the key access procedures.<br>2) As 95% of use of these gates is for weekly refuse collection purposes, we have changed our policy for accessing the keys for the main gate to require two staff members to unlock and lock the gate for all purposes except emergency evacuation purposes.<br>3) We expect that two staff will monitor the situation better each time access to the outside is needed. As this may be an inconvenience to staff temporarily, if the next few months see that no deficient practice is experienced and staff understand the importance of locking these gates and the access to the street, we may ease the policy with continued inspections by Management and the Administrator.<br>4) The Owner/Manager will be responsible for implementing the Policy.<br>5) 12/15/2023 | 12/12/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 6035 | A. BUILDING _____ B. WING _____ | 12/12/2023 |

| 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 |
|---|---|---|---|---|
| 1830 SS= E | Infection Control Required Training<br><br>Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control designees completed 15 hours of infection control training (Employee #3 and #4). Findings include: Employee #3 (E3) E3 was hired in 2017 as a Caregiver. Review of E3's record lacked documented evidence of 15 hours of training concerning the control and prevention of infections from an approved organization. Employee #4 (E4) E4 was hired in 2009 as the Owner. Review of E4's record lacked documented evidence of 15 hours of training concerning the control and prevention of infections from an approved organization. On 12/12/23 in the morning, the Owner confirmed E3 and E4 were the respective primary and secondary infection control program designees. The Owner acknowledged that the required infection control and prevention training had not been completed for E3 and E4. Severity: 2 Scope: 2 | 1830 | 1) We had identified the Primary and Secondary persons responsible for completing the Infection Control training (15 hours ea.), and both have commenced the training through CDC Training Websites (**see attached sample certificates #1 & #2**).<br>2) The training had begun the day after the Inspection, with the Primary now already completed and the Secondary's training to be completed later, due to her vacation and Holiday schedule. We will have Secondary staff member complete before the end of the year.<br>3) All training is done with a procedure for tracking all staff as to when they took classes and when they are due for renewals. As this was a new individual training program with considerable hours involved, staff was not able to start as expeditiously since all training is done at the Group Home on the facility computer, for compliance reasons. Also, Management and staff were concentrating on new staff trainings and annual updating without putting the proper emphasis on this new Infection training.<br>4) The Owner/Manager will be responsible for implementing this POC.<br>5) Primary completed 12/25/23; all completed by 12/31/23 | 12/25/2023 |