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 _____	**06/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AS TIME GOES BY 5	**4149 JORY TRAIL, 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 a complaint investigation conducted at your facility from 06/25/21 to 06/30/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for six Residential Facilities for Group beds for persons with Alzheimer's disease and/or Category II residents. The census at the time of the survey was 4. The sample size was five. The facility received a grade of A. One complaint was investigated. Complaint #NV00064221 with three allegations was substantiated. Allegation #1 - A Caregiver yelled at a resident was substantiated, see Tag 0556. Allegation #2 - A Caregiver had a physical altercation with a resident by dumping water on the resident and banging a cup on the table was unsubstantiated based on interviews with two Caregivers, the Administrator and four residents who had not observed physical altercations between the Caregiver of concern and the resident in the past. There were no documented incidents and no disciplinary actions in the Caregiver of concern's file. Allegation #3 - The facility was understaffed and only had one staff member for all residents was unsubstantiated based on interviews with two Caregivers, the Administrator and four residents who indicated the facility had adequate staff to care for resident's needs. Review of the staffing schedule documented Caregivers were employed to work during the day and overnight. The investigation into the allegation included: Interviews with the facility Administrator, two Caregivers and four residents. Record review of five resident files, including the resident of concern, and five employee training files. Document review of incident reports, employee disciplinary reports, staffing schedules, employee agreement and resident rights. The findings and	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JUNE KERN Title: Adm Date: 07/08/2021

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.

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 _____	**06/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AS TIME GOES BY 5	**4149 JORY TRAIL, 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
	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:			

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 _____	**06/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AS TIME GOES BY 5	**4149 JORY TRAIL, 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
0556 SS= F	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on interview and document review, the Administrator failed to ensure verbal abuse toward residents was reported in a timely manner to the local authority. Findings include: On 06/30/2021 at 3:15 PM, the Administrator indicated Employee #1 yelled at a resident one year ago. The Administrator indicated another employee informed the Administrator of the incident at the time. The Administrator indicated the incident was not reported to the local office of Aging and Disability Services (ADSD) within 24 hours after it occurred. On 06/30/2021 at 3:30 PM, Employee #3 indicated Employee #1 yelled at Resident #2 in June of 2019. Employee #3 indicated the Administrator was notified on the day the incident occurred. On 06/30/2021 at 3:45 PM, the Administrator did not recall the June 2019 incident and acknowledged an incident report was not completed and it was not reported to ADSD within 24 hours after the incident occurred. Review of facility documentation lacked evidence the facility reported the incidents of verbal abuse within 24 hours after they occurred. Review of Resident Rights policy documented a resident will be free from abuse, neglect and exploitation on the part of facility staff or other residents and visitors. Severity: 2 Scope: 1	0556	1. Explain how you would correct specific findings cited in statement of deficiency. Report any abuse incident within 24 hours of occurrence to ADSD. 6/28/2021 corrected 2. Explain how you would ensure that the deficient practice does not recur. Include system changes(if applicable) and future monitoring practices. To ensure that all incident reports be promptly submitted within 24 hours of occurrence to ADSD. Have frequent meetings on how to handle difficult residents and reinforce behavior management practices. corrected on 6-28-2021 3. Provide the name and title of person who will ensure that the plan of improvement is implemented June Kern, Adm. corrected 6/28/2021 4. Provide the date the corrective action: staff terminated on 6/28/2021, following an internal investigation (will send termination letter if needed) corrected 6/28/2021	06/28/2021