

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2021
NAME OF PROVIDER OR SUPPLIER MAYHILL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 MAYHILL AVE, LAS VEGAS, NEVADA ,89121		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and infection control survey conducted at your facility on 12/07/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, with an endorsement for Alzheimer's disease and/or individuals with intellectual disabilities, Category II residents. The census at the time of the survey was five. Five resident files and four 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 non-discrimination 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 investigation, 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:			

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: PRUDENCE LANDICHO	Title: Administrator	Date: 01/13/2022
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NAME OF PROVIDER OR SUPPLIER MAYHILL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 MAYHILL AVE, LAS VEGAS, NEVADA ,89121		
(X4) ID PREFIX TAG 0936 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0936	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 01/13/202 2
	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 one of five residents had a tuberculosis (TB) test upon admission and yearly thereafter (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 03/05/20 with diagnoses including stroke, right-sided hemiparesis, high blood pressure, chronic obstructive pulmonary disease and depression. A review of R2's file revealed no TB testing results for year 2020 and no TB testing results for year 2021. On 12/07/21 in the afternoon, in an interview with the facility Owner/Caregiver it was confirmed that there were no TB testing results for R2. The Owner/Caregiver acknowledged that all residents require TB testing results upon admission and yearly thereafter. Severity: 2 Scope: 1		Patient #2 was admitted on 3-5-2020 with a tb test 1 and 2 dated 2-22-2020. Unfortunately the reading date of TB #2 did not reflect on the paperwork. However it was indicated that the test is negative. So on Nov 17, 2020 he had his 1st tb test which is show negative. Because of the pandemic, we have difficulty of getting someone to come to our facility for his annual tb test. Patient #2 was able to get QuantiFERON test on 12-09-2021 which shows negative. I have a meeting with my caregivers to make sure that this things will never happen again. Administrator and caregivers are responsible to make sure that all paperwork is complete and will checked every month. Administrator is in charge for compliance. Corrective action taken 1.13.2022	