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
	61	A. BUILDING _____ B. WING _____	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYHILL MANOR	**3855 MAYHILL AVE, LAS VEGAS, NEVADA ,89121**

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0000	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 1/3/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 6 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease and individuals with intellectual disabilities, Category II residents. The census at the time of the survey was 5. Five resident files and four employee files were reviewed. The facility received a grade of B. 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 deficiencies were identified:	0000		

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure a Clinical Laboratory Improvements Amendment (CLIA) license and an Exempt Laboratory license issued by the State of Nevada Department of Public and Behavioral Health was obtained prior to conducting laboratory COVID-19 testing for 4 of 5 residents (Residents #1, #2, #3, and #4). Findings include: On 01/03/23 at 10:00 AM, two boxes of Over-the-Counter (OTC) COVID-19 antigen testing kits with a prescription label for Resident #1 (R1) were in a file cabinet in the entryway of the facility. On 01/03/23 in the morning, in the entryway area of the facility, COVID-19 test result sheets for Resident #1, #2, #3, and #4 were stored, which contained the name of the resident, the date of the test, and the result of the test. The actual test kit that had been used was secured to each individual test result sheet. All residents' results were negative for COVID-19. The facility lacked documented evidence of a CLIA or Exempt Laboratory license was obtained prior to performing COVID-19 testing. On 01/03/23 at 10:01 AM, the Caregiver reported COVID testing was performed when residents were suspected of being positive for COVID-19. Severity: 2 Scope: 3	0050	At the height of Covid 19 are staff give Covid Test to our residents. He didn't know about CLIA. We are just thankful that all residents are safe and healthy. I have a meeting with my caregivers to ensure all exemptions will be taken before covid testing is done. Administrator is in charge to ensure for compliance.	01/31/2023

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to maintain the interior of the facility. Findings include: The wall, baseboards and flooring in the area leading from the entryway into the dining and living room area had water damage, the floorboards had lifted and were missing pieces and there was a large gaping hole in the laundry room wall behind the water heater. On 1/3/23 at 2:20 PM, a caregiver indicated they had asked the owner to repair the damage, but no repairs had taken place. Severity: 2 Scope: 3	0178	All repairs have been done at the facility, i will inspect the facility every week to ensure all are in good repair. Administrator is in charge for compliance.	01/31/2023

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to obtain an Ultimate User agreement to administer medications for 1 of 5 residents (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 3/22/22 with diagnoses including Alzheimer's disease and hypertension. R5's medication bin and Medication Administration Record for 2022 and 2023 documented the facility administered R5 medications. R5's file lacked documented evidence of an Ultimate User agreement signed by R5 or R5's representative allowing for medication administration by the facility. On 1/3/23 at 2:00 PM, the Caregiver acknowledged the absence of the Ultimate User agreement. Severity: 2 Scope: 1	0876	Ultimate user of Resident #5 was place on the old folder, I have a meeting with the caregivers to make sure all paperwork is complete and current. Administrator will check paperwork of residents as well as caregivers in a monthly basis. Administrator is in charge for compliance.	01/31/2023

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation and interview, the facility failed to destroy a medication after its expiration date, for 1 of 5 residents (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 3/22/22 with diagnoses of Alzheimer's disease and hypertension. R5's medication bin contained Lorazepam Con 2 milligrams (mg) per milliliter (ml); Discard 90 days after opening; Dispensed on 3/27/22 and Expired on 6/25/22. On 1/3/23 at 2:10 PM, the Caregivers were unaware the medication had expired and should have been destroyed. Severity: 2 Scope: 1	0885	I have a meeting with the caregivers to make sure all medication that are expired should be destructed and note. I will inspect all medication monthly to ensure that all regulations are followed. Administrator is in charge for compliance.	01/31/2023

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0999 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: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to keep toxic substances locked up and out of reach of residents. Findings include: On 1/3/23 at 9:50 AM, a can of Lysol disinfectant spray and a bottle of alcohol-based hand sanitizer were on the counter in a resident bathroom. Lysol all-purpose cleaner was underneath the sink in an unlocked cabinet in a resident bathroom. Disinfecting wipes, spray disinfectant, hand sanitizer, and perfume were on a table in the entryway area of the facility. A large pump bottle of hand sanitizer was on the floor in the entryway area and a bottle of hand sanitizer was in an unlocked drawer in the entryway table. On 1/3/23 at 2:15 PM a Caregiver acknowledged the presence and accessibility of the toxic substances to residents. Severity: 2 Scope: 3	0999	All toxic substances are now place in a lock drawer. Administrator and employees will make sure that all toxic substance should be placed in a safe and lock cabinet or drawers. I will inspect the home every week to ensure compliance.	01/31/2023