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
	6281	A. BUILDING _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME, LLC	**5858 PALMYRA AVE, 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 an annual State Licensure and infection control survey conducted at your facility on 12/14/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten beds for persons with Alzheimer's disease, Category II residents. The census at the time of survey was seven. Seven resident files and three employee files were reviewed. The facility received a grade of C. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination 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 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		

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: RACHEL DEGELBECK	Title: Administrator	Date: 01/16/2022

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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 and interview, the facility failed to implement safe infection control practices for the protection of residents and staff in response to the COVID-19 Pandemic. Findings include: On 12/14/21 at 8:00 AM, the Health Facility Inspector was not asked COVID-19 screening questions related to symptoms, travel history, and exposure to the virus. A temperature check was not performed prior to being allowed entry to the facility. The Administrator verbalized all visitors and employees should have been screened for temperature checks and asked screening questions related to COVID-19 symptoms. Severity: 2 Scope: 3	0050	1. All employees will be retrained regarding COVID screening, as well as keeping access to the facility limited to less than two visitors by appointment only. 2. Policy review will be signed and acknowledged by every employee. 3. Random surprise visits will be conducted as well as interviewing visitors to verify they were screened upon entering. 4. Administrator and Manager will be conducting policy checks. 5. Retraining completed 12/25/21. 6. Policy and training	12/29/2021

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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interviews, the facility failed to ensure the interior of the facility was free from safety hazards. Findings include: On 12/14/21 at 8:00 AM, during a facility tour a common area and laundry room were being renovated. The following was observed: -Multiple carpentry supplies including nails and screws. -Two cans of cement. -Exposed dry wall. -Electrical outlets with no outlet covers. The area was not closed off and was accessible to residents. The Caregiver and Administrator acknowledged the two rooms were being renovated. The Administrator acknowledged the rooms were unsafe and accessible to residents. The Administrator indicated both rooms should have been secured and inaccessible to residents. Severity: 2 Scope: 3	0174	1. A physical barrier will be installed at kitchen to restrict access. All tools and chemicals will be locked when not used. 2. A physical lockable barrier will restrict future resident access to construction areas. Along with signage to inform residents of restricted area. All residents were notified individually to not cross the barrier, as well as ongoing supervision. 3. Weekly walk throughs will ensure construction area is locked and kept safe. 4. Owner will install new barrier, administrator will verify this barrier is installed and remains locked. 5. Installed on 12/25/21. 6. Photos	12/29/2021

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0930 SS= F	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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation and interview, the facility failed to ensure files for 7 of 7 residents were secured to prevent unauthorized use. Findings include: On 12/14/21 at 8:10 AM, a file cabinet in a common area containing resident files was unlocked and not secured. The Caregiver acknowledged the residents' files were unlocked and not secured from unauthorized use. Severity: 2 Scope: 3	0930	1. File cabinet is locked. 2. All staff notified that file cabinet is locked at all times. 3. Random checks will verify file cabinet is locked. Notice placed on cabinet to remind it must remain locked at all times. 4. Administrator and Manager will ensure cabinet is locked randomly and per use. 5. Locked and labeled on 12/20/21. 6. Photo	12/20/2021

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0991 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: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm system was activated on 1 of 3 doors exiting the facility. Finding include: On 12/14/21, at 8:15 AM, during a tour of the facility, the audible alarm system on the exit door leading to the backyard was not activated. The Caregiver acknowledged the alarm was not working. The Administrator verified the exit door alarm was inoperable. The Administrator indicated all door alarms should have been working. Severity: 2 Scope: 3	0991	1. New chime will be installed on back door. All chimes on all exits were verified to be in working condition. 2. Chimes will be checked monthly during routine maintenance inspections. 3. Administrator and Manager will routinely check door alarms. 4. Administrator and Manager 5. Chime installed 12/25/21. 6. Photo	12/29/2021

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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 ensure toxic substances were not accessible to residents. Findings include: On 12/14/21 at 8:20 AM, the following toxic substances were accessible to residents and found in the unlocked laundry room, pantry, and hallway bathroom: -Three bottles of bleach. -Two jugs of liquid fabric softener. -Two cans of liquid cement. -One jug of Fabuloso. -Two cans of Comet. -Four bottles of disinfectant spray. -One bottle of glass cleaner. -One bag of dishwasher pods. The Caregiver acknowledged the toxic substances should have been secured. Severity: 2 Scope: 3	0999	1. A physical barrier will be installed at kitchen to restrict access. All tools and chemicals will be locked when not used. 2. A physical barrier will restrict future resident access to construction areas. Along with signage to inform residents of restricted area. Residents were notified individually to not cross the barrier. 3. Weekly walk throughs will ensure construction area is locked and kept safe. 4. Owner will install new barrier, administrator will verify this barrier is installed and remains locked. 5. Installed on 12/25/21. 6. Photos	12/29/2021