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 _____	**03/30/2022**

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 a complaint investigation initiated at your facility on 03/14/22 and completed on 03/30/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was eight. The sample size was six. There was one complaint investigated. The facility received a grade of A. Complaint #NV00065854 with four allegations was not substantiated. The following allegations could not be substantiated: Allegation #1: A resident was not receiving adequate meals to meet specialized dietary needs was not substantiated based on a review of the resident's file; there were no physician's orders found in the resident's file documenting the resident was under physician's orders to receive a specialized diet. Allegation #2: Resident admitted to hospital with trauma to spine and ribs as a result of a fall was unsubstantiated based on a hospital discharge summary dated 01/12/22 and interview with the Administrator, which revealed the resident was admitted to the hospital for weakness after a bowel movement. An interview with a Detective from the Metropolitan Police Department on 03/22/22, indicated a review of the resident of concern's medical records determined the resident had suffered from underlying conditions and a previous fall with injuries before moving into the facility and the records failed to indicate the resident had a fall that caused her death. Allegation #3: A resident was not regularly bathed and/or showered and not properly escorted around the facility was unsubstantiated based on interviews with five residents who verbalized they were assisted with personal hygiene care and were allowed to move around the facility independently or with assistance of staff. Observation of residents walking around the	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: RACHEL DEGELBECK | Title: Administrator | Date: 04/14/2022

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.

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	facility, with assistance from Caregivers. A review of the resident of concern's activities of daily living assessment documented the resident used a wheelchair/walker and a physical exam dated 6/20/2021, documented resident was alert and oriented and had movement to all four extremities but overall generalized weakness. Interviews with Caregivers and Administrator who reported the resident was assisted around the facility while using a walker. Allegation #4: Resident had a change in condition from a fall and family was not notified was unsubstantiated based on interview conducted with the Administrator revealed the resident was transported to the hospital on 12/26/21 for stomach pain and the resident's family member was notified the resident was being transported to the hospital. A hospital discharge summary dated 01/12/22, revealed the resident was admitted to the hospital for weakness after a bowel movement, which resulted in a gastric ulcer. The investigation into the allegations included. Observations of facility environment, interactions between Caregivers and residents, residents walking inside and outside of the facility. Interviews with five residents, three Caregivers and the Administrator. Review of six residents' files including ADL assessment, dietary needs, History and Physical examinations, medical records and Admission Agreement. Document review of the Menus, Resident Rights, Staffing Schedule, Falls policy, Medical Emergencies, Incident Report policy, and Incident reports for the year of 2021-2022. 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 deficiencies unrelated to the complaint allegations were identified.			

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0253 SS= F	Adequate Supplies of Food - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. Inspector Comments: Based on observation and interview the facility failed to ensure a 2-day supply of fresh food was available for 8 of 8 residents. Findings include: On 03/14/22 at 9:50 AM, during a tour of the facility, one small bag of grapes was observed in the refrigerator and five apples were in a bowl on top of the kitchen counter. A Caregiver acknowledged there was one small bag of grapes and five apples. The Caregiver indicated the facility went grocery shopping once every two weeks. The Administrator acknowledged there was not a two-day supply of fresh foods in the facility. The Administrator verbalized there needed to be at least a week of fresh foods in the facility. Severity: 2 Scope: 3	0253	1. Weekly inspection of refrigerator and pantry to ensure a full supply of fresh foods. If low, facility will place an order for groceries. 2. Manager will inspect refrigerator and pantry. Administrator will ask residents if fresh food is being made available. 3. Weekly photographs sent to manager and/or an in-person inspection. 4. Manager and Administrator. 5. 04/14/2022 6. photo of recent fresh food supply	04/14/2022

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0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report was generated when a resident was hospitalized. (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/11/21, with diagnoses including liver cirrhosis and fracture of cervical spine. R1 was transferred to the hospital by paramedics for weakness and diarrhea on 12/26/21. R1's file lacked documented evidence an incident report was completed. On 03/14/22, the Administrator acknowledged R1 was transferred to the hospital by paramedics for weakness and diarrhea on 12/26/21 and an incident report was not completed. The facility was unable to provide documentation an incident report was completed. The facility's policy titled Medical Emergencies, documented "A resident will receive emergency medical care when needed to prevent illness and injuries; and an incident report would be completed." Severity: 2 Scope: 1	0853	1. Staff were trained on appropriate documentation 2. Policy was re-reviewed by staff and retrained by manager. A new formal incident report was created and staff was instructed on use of the new form. 3. Manager and administrator will ensure documentation policy is enforced along with a daily shift report. They will also ensure blank copies are always available in the incident binder. 4. manager and adminiistrator 5. 3/15/2022 6. attached incident report	03/15/2022