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 _____	**07/05/2022**

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 completed in your facility on 07/05/22, in accordance with Nevada Administrative Code (NAC) 449, Residential Facility for Groups. The census at the time of the survey was 10. The sample size was 1. The facility received the grade of A. One complaint was investigated. Complaint #000066428 with one allegation was substantiated. Allegation #1 - The facility had Alzheimer's residents living downstairs and the upstairs of the facility was being used for temporary housing for homeless individuals was substantiated. (See TAG 53). 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. There following regulatory deficiencies were identified.	0000		
0053 SS= F	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on observation, interview and record review, the Administrator failed to ensure newly admitted residents had files available and onsite for 3 of 10 sampled residents (Resident #1, #2 and #3) Findings include: On 07/05/22 at 9:15 AM, three residents were observed in the upstairs part of the facility. On 07/05/22 at 10:00 AM, Resident #1 (R1) reported to being placed in the facility by another agency and had been residing at the facility for a month. R1 revealed to getting three meals a day and medication was held and administered by	0053	What corrective actions(s) will be accomplished for those residents found to have affected by the deficient Practice: Residents That were effected by this practice were discharged back to the community. How will you identify other residents having the potential to be affected by	07/25/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARCE CASAL Title: Administrator Date: 08/04/2022

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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	staff daily. The medications were locked in a kitchen cabinet. Residents #2 and #3 were not available for interview. On 07/05/22 at 10:20 AM, the House Manager acknowledged the three new residents residing upstairs in the facility did not have files or documentation available for review during complaint survey. Severity: 2 Scope: 2		the same practice and what anticipated corrective action will be Taken? A complete audit was conducted on all resident charts. What measures will be in place to ensure deficient practice does not occur? A monthly audit will be conducted moving forward to insure compliance with all required documentation for resident charts. How will the facility monitor its Corrective actions? Monthly QAPI will be conducted.	
1010 SS= F	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an	1010	What corrective actions(s) will be accomplished for those residents found to have affected by the deficient Practice: All three residents were discharged back to the community.	08/22/2022

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	existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on interview, the facility failed to obtain a mental illness endorsement prior to admitting 3 of 10 residents with mental disorders. Findings include: On 07/05/2022 at 10:20 AM, the House Manager verified three newly admitted residents had a mental illness diagnoses and were living on the second floor of the facility. The House Manager further confirmed the facility lacked a mental illness endorsement. Review of Bureau of Health Care Quality and Compliance online licensing system revealed the facility lacked a Mental Illness endorsement and had no application pending to add the endorsement. Severity: 2 Scope: 3		How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be Taken? no other residents were effected by this practice. What measures will be in place to ensure deficient practice does not occur? The community will be divided and access to the licensed group home will not be allowed. only residents that meet the licensed criteria will reside. How will the facility monitor its Corrective actions? Monthly inspections will be conducted to insure only residents that meet the license will be allowed to live in the community.	