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 _____	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME, LLC	**5858 PALMYRA AVE, LAS VEGAS, NEVADA ,89146**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and a infection control State Licensure survey completed at your facility on 10/04/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of C. 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 deficiency was identified:	0000		

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0072 SS= D	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees received initial 16 hours of medication management training. Employee #3 was hired (no hire date provided by the facility) as a Medication Technician. The employee file documented an 8-hour refresher training certificate obtained on 05/05/22 and lacked documented evidence of a 16-hour medication training certificate. On 10/04/22 at 1:30 PM, the Administrator acknowledged Employee #3 did not have initial 16-hour mediation management training. Severity: 2 Scope: 1	0072	**What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Employee #3 has been removed from her duties as a medication Technician due to her inability to provide the original 16 hour course certificate. She has been scheduled to take the Original 16 hour course again on 11/09/2022 once this course has been completed she will produce the original certificate for her file. **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** All resident have the potential of being affected. Employee#3 has been relieved of her duties of passing medication until she can produce aoriginal copy of the 16 hour Medication Certification. **What measures will be in place to ensure the deficientpractice does not occur?** New Training standards and new hire orientation protocolshave been established and copies of the new electronic files will be kept atboth the Corporate HR Office as well asthe community. **How will the facility monitor its corrective actions?** The Resident Care Coordinator will conduct monthlyaudit on all employee files to ensure compliance	11/11/2022

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0102 SS= E	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure a physical examination was completed for 1 of 4 employees (Employee #3) and a two-step tuberculosis (TB) test was completed for 1 of 4 employees (Employee #4). Findings include: Employee #3 (E3) E3 was hired as a Medication Technician (no hire date provided by the facility). E3's file lacked documented evidence of a physical examination. Employee #4 (E4) E4 was hired on 11/25/21 as a Caregiver. E4's file lacked documented evidence of a two-step TB test. On 10/04/22 at 1:30 PM, the Administrator acknowledged E3 did not complete a physical examination and E4 did not complete a two-step TB test. Severity 2 Scope 2	0102	**What Corrective Action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** Employee #3 was sent for a physical Employee #4 was sent toconduct a two step TB test Results are pending **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** All residents had the potential of being affected. new hireorientation protocols have been established and copies of the new electronicfiles will be kept at both the Corporate HR Office as well as the community. **What measures will be in place to ensure the deficientpractice does not occur?** All new Hire employees will be sent to our clinic and copiesof the new electronic files will be kept at both the Corporate HR Office aswell as the community. **How will the facility monitor its corrective actions?** The Resident Care Coordinator will conduct monthly audit onall employee files to ensure compliance.	11/18/2022

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0104 SS= E	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure a background check was initiated and completed through the Nevada Automated Background Check System (NABS) for 2 of 4 employees (Employee #3 and #4) Findings include: Employee #3 (E3) E3 was hired as a Medication Technician. E3's file lacked documentation of a hire date and documented evidence of a background check through the Nevada Automated Background Check System (NABS). Employee #4 (E4) E4 was hired on 11/25/21 as a Caregiver. E4's file lacked documented evidence of a background check completed through NABS. On 10/04/22 at 1:30 PM, the Administrator acknowledged E3 and E4 did not have current background checks for the facility through NABS. Severity: 2 Scope: 2	0104	**What Corrective Action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** Both Employee #3 and #4 have been removed from the communityand new applications in NABS have been submitted for background checks. Verification has been completed that they areboth eligible for employment. **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** All residents had the potential of being affected. new hireorientation protocols have been established and copies of the new electronicfiles will be kept at both the Corporate HR Office as well as the community. **What measures will be in place to ensure the deficientpractice does not occur?** All new Hire employees will be sent to electronicfingerprinting and copies of the new electronic files will be kept at both theCorporate HR Office as well as thecommunity. **How will the facility monitor its corrective actions?** The Resident Care Coordinator will conduct monthly audit onall employee files to ensure compliance.	11/11/2022

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0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR) accurately documented the medications for 1 of 8 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 02/01/22, with diagnoses including heart failure, chronic bilateral pleural effusions, and chronic back pain. R2's Medication Administration Record (MAR) for October 2022, documented furosemide 40 milligrams (mg) take one tablet by mouth twice a day. R2's medication bottle was labeled, furosemide 40 mg, take one tablet by mouth once daily. On 10/04/22 at 1:30 PM, the Administrator acknowledged R2's medication bottle did not match R2's MAR. Severity: 2 Scope: 1	0895	**What Corrective Action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** Resident #2 was discharged back to independent living in thecommunity **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** No other resident was affected. **What measures will be in place to ensure the deficientpractice does not occur?** Weekly Med Cart Audit will be conducted by the Medication Technicianand the RCC for accurate documentation. As well as quarterly Pharmacy reviews. **How will the facility monitor its corrective actions?** Resident Care Coordinator will conduct monthly audit of allmedication administration records as well as weekly Medication audits.	10/21/2022

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0933 SS= E	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: (d) A statement from the resident ' s physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. Inspector Comments: Based on interview and record review, the facility failed to obtain a Physician Placement Determination upon admission for 3 of 8 residents (Resident #2, #3, and #5). Findings include: Resident #2 (R2) R2 was admitted to the facility on 02/01/22, with diagnoses including heart failure, chronic bilateral pleural effusions, and chronic back pain. R2's file lacked a Physician Placement Determination form. Resident #3 (R3) R3 was admitted to the facility on 03/01/22, with diagnoses including paraplegia, depression, and neuralgia. R3's file lacked a Physician Placement Determination form. Resident #5 (R5) R5 was admitted to the facility on 05/20/22, with diagnoses including legal blindness and mild cognitive impairment. R5's file lacked a Physician Placement Determination form. On 10/04/22 at 1:30 PM, the Administrator acknowledged a Physician Placement Determination was not obtained for R2, R3, and R5. Severity: 2 Scope: 2	0933	**What Corrective Action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** Resident #2 was discharged to the community Resident #3 andResident #5 were seen by the primary care provider and assessed forplacement. **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** No other residents were affected by this deficient practice. **What measures will be in place to ensure the deficientpractice does not occur?** All Admission processes have been audited and a admissioncheck list has been created for compliance. **How will the facility monitor its corrective actions?** Resident Care Coordinator will conduct monthly audit of alladmission records.	11/03/2022

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0994 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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were securely stored and were inaccessible to residents. Findings include: On 10/04/22 at 10:00 am, three bottles of perfume were found on top of a dresser in room #5, a bottle of Pepto Bismol was on a nightstand in room #6, three bottles of over-the-counter vitamins were on the bottom shelf of a nightstand in room #7, and a box of twenty-four count over-the-counter anti-diarrheal caplets in room #3. The Administrator acknowledged all toxic substances should have been stored in a secure area in the facility. Severity: 2 Scope: 3	0994	**What Corrective Action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** A Community wide inspection was conducted, and all toxicsubstances were removed from any and all access points. Resident specific baskets were created whereall supplies will be individually stored in a locked cabinet in the resident'sroom or in our locked medication room for safety. Family members andresponsible parties were notified to make staff aware of any toxic substancesbeing brought into the community need to be given to staff for safety reasons. **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** No other residents were affected by this practice. **What measures will be in place to ensure the deficientpractice does not occur?** Staff will conduct routine rounds to ensure no toxicsubstances are being kept unlocked or accessible. Resident Care Coordinator will conductunannounced weekly inspections to validate no toxic substances are accessible inthe community.	10/07/2022
1540 SS= F	Cultural Competency Training Inspector Comments: Based on record review and interview, the facility failed to: submit an application for a cultural competency training program, in compliance with R016-20; and ensure 4 of 4 sampled employees were in compliance with Nevada Revised Statutes (NRS) 449.103, regarding initial cultural competency training. (Employee #1, #2, #3,	1540	**What Corrective Action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** We have submitted our Cultural Competencycourse for Divisions approval on 10/21/2022 and hoping to get it approved within 30	11/30/2022

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	and #4) Findings include: Employee #1 (E1) E1 was hired on 11/30/21 as a Caregiver. E1's file lacked documented evidence of initial cultural competency training. Employee #2 (E2) E2 was hired on 09/09/21 as a Caregiver. E2's file lacked documented evidence of initial cultural competency training. Employee #3 (E3) E3 was hired on 05/01/21 as a Medication Technician/Caregiver. E3's file lacked documented evidence of initial cultural competency training. Employee #4 (E4) E4 was hired on 11/25/21 as a Caregiver. E4's file lacked documented evidence of initial cultural competency training. On 10/04/22 at 1:30 PM, the Administrator confirmed the facility had not submitted an application for a cultural competency training program and E1, E2, E3, and E4 had not completed initial cultural competency training. Severity: 2 Scope: 3		days and then beable to train staff within 30 days of approval. If we do not get approved, wewill use the Cultural Competency Program by Nevada Cultural Competency Course ID#CCT-2021-002. **How will you identify other residents having thepotential to be affected by the same practice and what anticipated correctiveaction will be taken?** Some residents have the potential to be affected by thisdeficient practice. our company's HR department will incorporate this trainingas part of the onboarding process of all new employees and will also make surethat they receive copies of the certificate of all current employees for their HR file. **What measures will be in place to ensure the deficientpractice does not occur?** We have revised the Employees checklist to includecompletion of the Cultural Competency Training as a requirement so that status willneed to be updated as soon as training is completed for current employees. For newemployees, HR will not complete the onboarding process without copy of the training certificate. **What measures will be in place to ensure the deficientpractice does not occur?** HR supervisor will work closely with the Housing Operationsmanager in making sure that all staff has the required training. And	

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			Monthly employeefile audits will be conducted in the community for compliance.	