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 _____	**07/11/2024**

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 07/02/24 and completed on 7/11/24, 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 four. The sample size was five. The facility received a grade of C. There was one complaint and one Facility Reported Incident (FRIs) investigated: Substantiated: 1. Complaint #NV00071557 was substantiated. (See TAGS Y0050, Y0967, and Y0995) 2. FRI #10133 was substantiated. (See TAG Y0967) The investigation of the Complaint included: Observation of grooming and physical appearance for residents, residents receiving care and assistance, resident rooms, alarms on doors, locks on the backyard gate, locks on the facility doors, and tour of the facility. Interviews were conducted with residents, the resident of concern, a Security Guard, two Caregivers, a Public Guardian, a Psychiatric Case Worker, the Resident Care Coordinator, and the Administrator's Designee. Clinical Record Review of 5 records, which included the residents of concern. Three employee files were reviewed. Document review included facility policy and procedures, employee schedules, and admission documents. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NICHOLE SCHMAL Title: Executive Director Date: 09/11/2024

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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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 record review and interview, the facility failed to ensure 3 of 5 residents (Resident #1, #3 and #5) were assessed and admitted appropriately based on the resident's primary diagnosis of mental illness in an Alzheimer's endorsed facility and failed to ensure protective supervision for 2 of 5 residents (Resident #1 and #5). Findings include: Resident #1 (R1) R1 was admitted to the facility on 04/02/24, with diagnoses including schizophrenia, hypertension and dyslipidemia. A Person Centered Service Plan dated 03/29/24 signed by R1's physician documented R1 was not capable of physically and mentally leaving the facility on their own. A Client Treatment Plan dated 05/15/24 documented R1 was diagnosed on 05/02/24 with schizophrenia and was determined as having a Serious Mental Illness. The facility was to monitor R1 to ensure their safety and well-being 24 hours a day. The facility's Residential Services Incident Report dated 06/26/24 at 8:00 AM documented R1 eloped from the facility on 06/26/24. The Caregiver went into R1's room and noticed R1 was not in their bedroom and was nowhere to be found at the facility. The Caregiver notified their supervisor and the police. An Outpatient Services Incident Report from a local mental health hospital dated 06/26/24 documented R1's Case Worker met with an Occupational Therapist at 11:10 AM on 06/26/24 who reported R1 was missing from the facility when the Occupational Therapist	0050	1. We will correct this specific finding by having the Administrator provide oversight and direction for the staff of the facility as necessary to ensure that the residents receive needed services and protective supervision, and that the facility is in compliance with the regulations via a daily End Of Shift Report email sent to the Manager, Resident Care Coordinator and Owner. We have an admissions form that is completed before arrival into the facility. This document is signed by the physician before the resident comes into the facility. An example would be, if someone is at risk of eloping then 30 minutes check is conducted on that resident, and staff will be documenting this via Docuwhiz.com on eMAR and in the End Of Shift Report. Also, they will report other odd behaviors that may lead up to elopement in the daily email that is sent to the Manager, Resident Care Coordinator and owner. 2. The measure of change that will occur is the administrator and manager and owner will provide oversight and direction to the staff of the facility as needed to ensure that the residents receive needed services and protective supervision form this email. This email will include the following. Staff currently working, staff coming on next shift, any intakes or discharges, any resident not in service, any resident on isolation, any medication/food received, staff notes and maintenance. 3. This corrective action will be monitored daily via that End Of Shift Report email by all parties. 4. The administrator will be responsible for ensuring the plan of correction is implemented. 5. August 7, 2024, is the date the corrective action will be completed. 6. Please see attached email sample of oversight and direction and 808 form for Livingston Home 7. Including other information on these emails will help to identify and correct other areas having potential to be affected by the	08/07/2024

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	visited the facility earlier that morning. R1's Case Worker was then contacted by a Caregiver from the facility at 11:12 AM on 06/26/24 who reported R1 had eloped from the facility. The Case Worker contacted the House Manager and Administrator of the facility on 06/26/24 to verify R1 had eloped from the facility. At 11:59 AM a Police Officer reported staff said R1 went missing at approximately 7:30 AM and the incident was reported to the police department at 9:23 AM. On 06/26/24 at 2:56 PM, the Case Worker received communication from the House Manager reporting R1 left the facility by climbing through another resident's bedroom window. R1 had opened the window, threw two bags of stuff out, and then climbed out the window. The incident was unnoticed by staff at the home. An Outpatient Services Incident Report from a local mental health hospital dated 06/26/24 at 5:00 PM, documented R1 showed up at their family member's house who verbalized that R1 could not be there. The House Manager then went and picked R1 up and brought R1 back to the group home. On 07/02/24 in the morning, the Security Guard confirmed R1 left the facility by opening a bedroom window after eating breakfast on 06/26/24 sometime between 7:30 and 8:00 AM. On 07/02/24 in the morning, a Caregiver confirmed R1 left the facility while the Caregiver was writing a grocery list in the kitchen. The Caregiver acknowledged last seeing R1 when R1 was eating breakfast. On 07/02/24 in the morning, the Administrator Designee acknowledged R1 eloped from the facility and verbalized the facility contacted R1's Case Worker immediately after contacting the police. On 07/08/24 in the morning, R1's Case Worker reported the facility was to provide their clients with 24 hour supervision in a locked facility. An Outpatient Incident Report from a local mental health hospital dated 07/07/24 documented R1 eloped again from the facility on 07/07/24 at approximately 4:30 AM. The Case Worker received		same deficient practice. In the email it conveys many other details to correct issues before they become a citation.	

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	communication from the facility via text at 5:03 AM. R1 left out of a window, pushed the screen out and shut the alarm on the window off. The House Manager reported at 4:30 AM, that staff were assisting another resident when the resident exited the window. The bedroom door was reportedly blocked with a table and a chair. As of 07/10/24, R1 was still not located. On 07/11/24 in the afternoon, the Administrator Designee acknowledged R1 had eloped from the facility again on 07/07/24. The Administrator Designee verbalized R1 left the facility at approximately 4:30 AM while the two Caregivers were assisting another resident who was a two person assist. Resident #3 (R3) R3 was admitted to the facility on 04/05/24, with diagnoses including schizophrenia and hypertension. An Inpatient Mental Health Hospital Exam dated 01/20/24 documented R3 was diagnosed with schizophrenia and presented to the emergency room with bizarre behavior and disorganized thoughts. A Client Treatment Plan dated 05/15/24 documented R3 was diagnosed on 03/27/24 with schizophrenia and was determined as having a Serious Mental Illness. R3 needed consistent administration of their behavioral health medications to maximize their safety, stability and independence. Resident #5 (R5) R5 was admitted to the facility on 03/12/24, with a diagnosis of schizoaffective disorder. A Physical from an inpatient Psychiatric Hospital dated 11/11/23 documented R5's chief complaint as schizophrenia with a past history of schizophrenia. R5 was noted to be aggressive and violent to staff and was sent to the emergency room. A Discharge Interdisciplinary Continuity of Care Plan from a Psychiatric Hospital dated 03/12/24 documented R5 as having schizoaffective disorder. The facility provided R5 with a psychiatric evaluation, psychosocial assessment, and nursing assessment. R5 was offered therapeutic groups and activities to help them cope with			

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	schizoaffective disorder. R5 was documented as being alert and oriented times 4 and being discharged to this group home where R5 would participate in aftercare treatment. A Facility Person Centered Service Plan dated 03/12/24 documented R5 was not capable physically and mentally to leave the facility on their own. R5 must be accompanied by Staff, the Administrator, the Designee, Family or Legal Guardian in order to leave the facility. The facility's Residential Services Incident Report dated 04/25/24 documented a Caregiver gave R5 their medications and then went to their room. After approximately 5 minutes, the Caregiver heard the noise of a door and went to R5's room. R5 was not in their room and the caregiver reported R5 went out the bedroom window and was no longer in the facility. An Outpatient Services Incident Report from a local mental hospital dated 04/25/24 documented R5's Case Worker was notified by the House Manager that R5 had eloped from the facility. The House Manager reported the facility had contacted the police department. The Case Worker instructed the House Manager to contact R5's Public Guardian. On 04/26/24, R5's Case Worker was informed R5 was found and returned to the facility. R5's whereabouts overnight from 04/25/24 to 04/26/24 were unknown. On 07/02/24 in the morning, the Administrator Designee acknowledged R5 eloped from the facility on 04/25/24 by exiting the facility through a window. The Administrator Designee reported R5 was located on 04/26/24 at an outpatient clinic where they picked up the resident and returned them to the facility. On 07/02/24 in the afternoon the Administrator Designee acknowledged the facility did not have a mental illness endorsement. Resident Admission Agreements contain a Facility Policy dated 09/21/17 which documented residents would not be allowed to leave the facility unescorted and that supervision would be provided on a twenty-four basis in the			

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	facility. Severity: 2 Scope: 3 Complaint #NV00071557			
0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview the facility failed to ensure two residents' bedroom windows had a screen. Findings include: On 07/02/24 in the morning, a tour of the facility revealed Bedroom #6 at the back of the facility and Bedroom #7's window at the front of the facility were without screens. On 07/02/24 in the morning, the Security Guard acknowledged the windows were missing screens. The Security Guard verbalized the screen missing at the front of the facility (Bedroom #7) was due to R1 leaving the facility unescorted through Bedroom #7's window on the morning of 06/26/24. Severity: 2 Scope: 1	0179	1. We have corrected this finding by adding a screen to the window. 2. The measure change that occurred was the window screen was reinstalled. 3. This corrective action will be monitored daily. 4. Caregivers will monitor this daily and report missing screens to manager. 5. August 8, 2024 this missing screen was replaced. 6. See attached picture of screen on window 7. We will identify daily if any other screens are missing by notification of staff.	08/07/2024
0967 SS= D	Alzheimer’s Care - NAC 449.2754 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behavior will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent	0967	1. We correct this specific finding by training staff. We discussed the policy and procedure for AWOL/ elopement of a resident and how to address the police or any other outside agency. 2. The measure that was put into place is that we had a mandatory meeting that day discussing the policy and procedures for AWOL or elopement of a resident. 3. This corrective action was monitored by conducting a training and in service with all staff. 4. This training was completed by the Manager and Administrator. 5. This training was held on July 26 2024 6. We have attached the training log and the policy and procedure addressing AWOL/elopement that were discussed at the meeting. 7. We also discussed all other policies and procedures that may come up and how to	08/07/2024

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	residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; Inspector Comments: Based on document review, record review and interview, the facility failed to follow their policies and procedures after the elopement of a resident. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted to the facility on 04/02/24, with diagnoses including schizophrenia, hypertension, and dyslipidemia. The facility's Residential Services Incident Report dated 06/26/24 at 8:00 AM documented R1 eloped from the facility on 06/26/24. The Caregiver went into R1's room and noticed the resident was not in their bedroom or on the property. R1 was nowhere to be found. The Caregiver notified their supervisor and the police. An Outpatient Services Incident Report from a local mental health hospital dated 06/26/24 documented R1's Case Worker met with an Occupational Therapist at 11:10 AM on 06/26/24. The Occupational Therapist reported R1 was missing from the facility when the Occupational Therapist visited the facility earlier that morning. R1's Case Worker was then contacted by a Caregiver from the facility at 11:12 AM on 06/26/24. The Caregiver reported to the Case Worker they did not contact the Case Worker immediately as their protocol was to contact the House Manager who was then supposed to contact the Case Worker. The Case Worker contacted the House Manager and Administrator of the faclility on 06/26/24 who verified R1 had eloped from the facility. The House Manager reported they were at another facility and did not get the message, which was why the Case Worker was not notified immediately when the incident occurred. On 06/26/24 at 11:59 AM the Case Worker received communication from the Police Department which reported they were awaiting camera footage from the facility to determine how R1 eloped from the facility. The Police Officer reported staff said		address incidents to avoid any other citations.	

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	R1 went missing at approximately 7:30 AM and the incident was reported to the police department at 9:23 AM. On 06/26/24 at approximately 2:00 PM, the Case Worker was contacted by the Police Department who reported the Caregivers were noncompliant with providing information about R1. The Police Officer verbalized that staff were inconsistent with the timeline of R1 missing and when questioned how R1 went missing without notice in a locked facility could not be answered. On 07/02/24 in the morning, a Caregiver verbalized the process was to immediately contact the police, the resident's responsible party and their supervisor. On 07/02/24 in the afternoon, the Resident Care Coordinator (RCC) acknowledged the Caregivers had not provided the Police Officer all R1's medical information and should have. Staff withheld R1's health information and the medication list because they were concerned about violating Health Insurance Portability and Accountability Act (HIPPA) regulations. The RCC reported providing the Police Officer the requested information once they arrived at the facility. On 07/08/24 in the morning, R1's Case Worker reported the Caregivers initially told the Police Officer R1 had a diagnosis of anxiety, and the staff did not initially disclose R1 was schizophrenic. The Police Officer described the Caregivers as incompetent and felt there were inconsistent timelines of R1's elopement. The Facility's Elopement Policy (undated) documented staff were to notify the police department and provide local law enforcement with the following: * Resident full bodied photo * Description of current clothing they were wearing * Any other physically identifying information * Information regarding current medication/treatment needs * Information regarding resident's nickname or typical behavior The policy lacked documented evidence of staff not to inform local police about resident's health information due to HIPPA. Severity: 2 Scope: 1 Complaint			

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0990 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845disease shall ensure that: (a) Swimming pools and other bodies of water are fenced or protected by other acceptable means. Inspector Comments: Based on observation and interview, a facility endorsed for Alzheimer's disease failed to ensure a pool was secured from residents. Findings include: On 07/02/24 in the morning, a pool in the rear yard was observed surrounded by fencing. Both gates which provided access to the pool had no locks. On 07/02/24 in the morning, the Security Guard acknowledged the pool gates had no locks on them. The Security Guard verbalized pool gates should have locks on them at all times. Severity: 2 Scope: 3	0990	1. We have corrected this specific finding by placing a lock on the pool gate. Note there is a pool safety cover on the entire pool which holds up to 1000lbs and the pool no longer has water in it. 2. The measure of change is a pool lock was added to the gate and all other gates leading to the backyard. 3. Daily the lock will be on the pool and all the back gates. Manager and Staff have a key of these gate locks and will keep gate locked at all times. 4. The manager will change the lock if it comes off or breaks. 5. August 7 2024 the lock was added to the secure pool 6. See attached picture of the existing secure pool cover with lock on gate. Also, all other gates are locked to avoid elopement. 7. The gate is locked with no intention of removing the lock and a secure pool cover that already was on the pool will remain so no other means will be needed.	08/07/2024

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0995 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure a gate leading to the main road was properly locked and secured. Findings include: On 07/02/24 in the morning, a gate on the left side of the home, separating the back yard from the front yard and main road, was found unlocked. On 07/02/24 in the morning, the Security Guard confirmed the gate on the left side of the home had no lock and was unsecured. Severity: 2 Scope: 3 Complaint #NV00071557	0995	1. We have corrected this specific finding by adding a lock to the back gate. 2. The measure of change that occurred is that a gate lock was added to the side gate. 3. This lock will be monitored daily. 4. The care staff will report any change of lock to manager. 5. August 7, 2024 this lock was added. 6. See picture of gate locked 7. We will be informed of any unlocked gates on property by the care staff to stop potential deficient practice.	08/07/2024
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.	1010	1. We will correct this finding by applying for a mental illness endorsement 2. The measure take is to apply for the mental illness endorsement 3. This will be monitored daily until completed. 4. The manager will be in charge of this correction. 5. August 7, 2024 this was corrected. 6. See application attached 7. We will apply for all endorsements that	08/07/2024

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(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
	The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on interview, document review and record review, the facility failed to ensure the facility obtained a mental illness endorsement prior to admitting residents diagnosed with mental illness for 3 of 5 sampled residents (Resident #1, #3 and #5). Findings include: Resident #1 (R1) R1 was admitted to the facility on 04/02/24, with diagnoses including schizophrenia, hypertension and dyslipidemia. A Client Treatment Plan dated 05/15/24 documented R1 was diagnosed on 05/02/24 with schizophrenia and was determined as having a Serious Mental Illness. Resident #3 (R3) R3 was admitted to the facility on 04/05/24, with diagnoses including schizophrenia and hypertension. An Inpatient Hospital Exam dated 01/20/24 documented R3 was diagnosed with schizophrenia and presented to the emergency room with bizarre behavior and disorganized thoughts. A Client Treatment Plan dated 05/15/24 documented R3 was diagnosed on 03/27/24 with schizophrenia and was determined as having a Serious Mental Illness. R3 needed consistent administration of their behavioral health medications to maximize their safety, stability and independence. Resident #5 (R5) R5 was admitted to the facility on 03/12/24, with a diagnosis of schizoaffective disorder. A Physical from an inpatient Psychiatric Hospital dated 11/11/23 documented R5's chief complaint was schizophrenia with a past history of schizophrenia. R5 was noted to be aggressive and violent to staff and was sent to the emergency room. A Discharge Interdisciplinary Continuity of Care Plan from a Psychiatric Hospital dated 03/12/24 documented R5 as having schizoaffective disorder. The facility provided R5 with a		may arise, so this does not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/11/2024**

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	psychiatric evaluation, psychosocial assessment, and nursing assessment. R5 was offered therapeutic groups and activities to help them cope with schizoaffective disorder. R5 was documented as being alert and oriented times 4 and being discharged to this group home where R5 would participate in aftercare treatment. A Facility Person Centered Service Plan dated 03/12/24 documented R5 did not have a diagnosis of Alzheimers Disease and did not have another form of dementia. A Client Treatment Plan dated 05/14/24 documented R5 was diagnosed on 04/09/24 with schizoaffective disorder and was determined as having a Serious Mental Illness. R5 needed consistent administration of their behavioral health medications to maximize their safety, stability and independence. Documentation review revealed a lack of evidence the facility had obtained or applied for an endorsement to provide care to persons with mental illnesses. On 07/02/24 in the afternoon the Administrator Designee acknowledged the facility did not have a mental illness endorsement. Severity: 2 Scope: 3			