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 _____	**08/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEERY CARE II	**271 E DESERT ROSE DR, HENDERSON, NEVADA ,89015**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 08/07/24, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The census at the time of the survey was 10. The sample size was one. One resident file was reviewed. The facility received a grade of B. There was one complaint investigated. Substantiated: 1. Complaint # NV00071822 was substantiated. (See TAGs Y050, Y850, Y991 and Y995) The investigation of the complaint included: Observations of facility residents, facility door alarms and gate locks and a tour of the facility. Interviews were conducted with the Manager and the Owner. Record review including the resident of concern and home video footage involving the resident of concern. Document review of facility policies and procedures, the Staffing Schedule and Incident Reports. 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 regulatory deficiencies were identified:	0000		
0050 SS= G	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, document review, record	0050	1. WE WILL PREVENT THIS FROM OCCURING BY routine checks for each resident completed every 2 hours. Door alarms are audible by at least one staff member at all times. Door alarms are checked each shift for functionality. Will also be checked weekly by manager or administrator. 2. It is policy that all residents are checked on every 2 hours minimum, and more often as needed. It is policy that door alarms remain on and working at all times. 3. Care staff is aware and trained on elopement procedures as well as policy	08/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: RACHEL DEGELBECK | Title: Administrator | Date: 11/15/2024

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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	review and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary protective supervision, for a resident who eloped from the facility. (Resident #1) Findings include: The facility is licensed for ten Residential Facility for Group beds for persons with Alzheimer's disease or related dementia, Category II residents. Resident #1 (R1) R1 was admitted on 12/02/23 with diagnoses including dementia, fall risk, weakness, unsteady gait and insomnia. The facility's initial History and Physical Report dated 01/15/24, documented R1 was ambulatory. A late entry Incident Report dated 08/07/24, documented on 07/28/24 at 6:00 AM, the Owner reported R1 was in the backyard. R1 then left the backyard by going out of the facility's back two gates after a Caregiver took the trash out. On 08/07/24 at 9:45 AM, the Manager reported receiving a call from a staff member at the facility on 07/28/24 between 8:00 AM and 8:30 AM indicating R1 was gone from the facility. The staff member reported the night Caregiver used the side area of the facility to park their car and may have left the gate unlocked. The Manager reported the neighbors informed facility staff R1 was across the street at their home. Facility staff were unaware R1 was gone from the facility. Home video footage of R1, provided by the neighbors who found R1, was reviewed on 07/31/24. Between 6:21 AM and 8:56 AM on 07/28/24, R1 was confirmed being seen in a blue sweater leaning on one of the neighbor's front stoops for approximately two hours, then moved to sit on the ground in front of the stoop. The neighbor reported to the facility R1 was lethargic and had bruises on R1's ankles. After the neighbors attempted to find out who R1 was and subsequently found out where R1 came from, the neighbors alerted the facility. Facility staff went to retrieve R1 after being notified by the neighbors. On 08/07/24 at 9:45 AM, upon R1's return to the facility, the Manager		regarding 2 hour minimum checks. Care staff will report immediately regarding door alarms or of missing resident during routine checks. 4. Care staff will report to manager and administrator. Manager and administrator will monitor for compliance. Also monitor Docuwhiz.com for resident checks. 5. 8/8/2024 6. n/a	

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	noticed R1 had a new ankle bruise and R1's feet were swollen. R1 was tired and slept most of the day upon return. R1 also reported R1's back hurt. The Owner called 911, however R1 refused to go to the hospital, reporting R1 was okay. R1 returned to the facility and was placed on a two-hour check for elopement. The Las Vegas Weather History for 07/28/24 documented temperatures at 90 degrees Fahrenheit at 5:56 AM, 93 degrees Fahrenheit at 6:56 AM and 95 degrees Fahrenheit at 7:56 AM. On 08/07/24 at 9:45 AM, the Manager explained R1 was a wanderer, wandered every night and was always trying to get out of the facility. The Manager confirmed R1 left the facility, unaccompanied, during the shift change on 07/28/24, which was at 7:00 AM. On the day R1 eloped, the back gate was ajar and the front door was ajar during the AM shift change. The Manager further explained R1 may have gone through two gates in the back to get outside of the facility, or R1 could have walked through the front door, as R1's departure was not witnessed. The Manager reported during shift change, the Caregivers were supposed to check the doors to see if they were alarmed and the residents to see if they were all accounted for. The night shift staff had a harder time keeping track of the residents because of the wanderers. On 08/07/24 at 10:10 AM, the Manager described the facility had five residents who were wanderers, including R1, and it had been tricky to monitor them. On 08/07/24 at 10:40 AM, the Owner described the Caregiver on duty for the 07/28/24 night shift reported taking the trash out and R1 followed the Caregiver out. The Caregiver did not lock the door and R1 left west from the back of the facility, then across the street. The facility's Elopement policy (undated), documented elopement precautions and response procedures were carried out for resident safety. The facility is secured 24/7. The facility's Missing Person - General Procedure policy (undated),			

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	documented staff shall remain alert and follow redirection techniques if a wandering resident gained access to any exit areas ... Routine safety checks would be made by staff. The facility's Missing Resident policy (undated), documented staff alerted the immediate supervisor to begin a thorough search of the entire community area. The Administrator was notified immediately. The Administrator or designee alerted other departments to ensure the entire community was on alert. This would include any law enforcement needed. There was no documented evidence in R1's record or in facility documentation that the facility staff began a search of the area and notified the Administrator once they realized R1 was gone from the facility. The facility's Missing Person - When Resident Returns to Community policy (undated), documented the facility would obtain an updated medical evaluation from the hospital or doctor's office. Maintain resident behavior monitoring for identification of any triggers. Complete resident record documentation. Update service plan and resident summary to reflect potential elopement. The facility's Person Centered Plan policy(undated), documented the plan would include topics such as cognitive safety, outline of protective supervision requirements and how staff will be informed of protective requirements ... If a resident had a diagnosis of dementia/ALZ, measures to ensure safety of the resident in the facility including, how behavior would be managed; how staff would prevent residents from wandering from the facility; what actions staff would take if a resident wandered from the facility; and confirm that operational alarms/buzzers for notifying staff when a door was opened were installed on all doors that may be used to exit the facility. Severity: 3 Scope: 1 Complaint #NV00071822			
0850 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical	0850	1. Per policy, upon immediate notice of resident elopement, physician, POA (or responsible party), and administrator will be	08/08/2024

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	examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on observation, document review, interview and record review, the facility failed to provide documented evidence notification was made to the responsible party and physician of a resident who eloped from the facility and sustained injuries. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 12/02/23 with diagnoses including dementia, fall risk, weakness, unsteady gait and insomnia. On 08/07/24 at 9:45 AM, the Manager reported receiving a call from a staff member at the facility on 07/28/24 between 8:00 AM and 8:30 AM indicating R1 was gone from the facility. The Manager reported the neighbors informed facility staff R1 was across the street at their home. Facility staff were unaware R1 was gone from the facility. Facility staff went to retrieve R1 after being notified by the neighbors, and it had been identified R1 had eloped from the facility. Home video footage of R1, provided by the neighbors who found R1, was reviewed on 07/31/24. Between 6:21 AM and 8:56 AM on 07/28/24, R1 was confirmed being seen in a blue sweater leaning on one of the neighbor's front stoops for approximately two hours, then moved to sit on the ground in front of the stoop. The neighbor reported to the facility R1 was lethargic and had bruises on R1's ankles. On 08/07/24 at 9:45 AM, upon R1's return to the facility, the Manager noticed R1 had a new ankle bruise		notified by care staff. This will be also documented in an incident report on docuwhiz.com. 2. Care staff is retrained on policy for documenting elopements and who to report to. 3. Daily checks by manager and weekly checks by administrator for compliance of incident reporting documentation. 4. Care staff is responsible for reporting immediately to manager and administrator. Manager and administrator will confirm that policy is followed to notify physician and responsible party/POA. 5. AUGUST 8 2024 6. ATTACHED IS OUR FACILITY POLICY AND RESIDENT RIGHTS AND DOCUWHIZ INDICENT REPORT ON SAID RESIDENT AND WHAT HAPPENED. THIS WAS IN DOCUWHIZ.COM UNDER THE ACHIVED RESIDENT AND IS ATTACHED GMAIL FOR SURVEYOR. 7. WE WILL CONTINUE TO DOCUMENT ALL INCIDENTS IN THE NON MEDICAL CARE HOME AND INFORM ALL SAID PARTIES OF ALL INCIDENTS WHEN THEY OCCURE.	

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	and R1's feet were swollen. R1 was tired and slept most of the day upon return. R1 also reported R1's back hurt. On 08/07/24 in the afternoon, R1's record lacked documented evidence R1's family member or R1's physician were notified of the incident and of R1's injuries. R1's record lacked documented evidence of R1 being sent to the hospital on 07/28/24 after eloping from the faciity. The facility's Missing Person - If Resident Is Found policy (undated), documented the facility staff conducted an assessment to identify possible injuries. Transfer the resident to the hospital for further medical evaluation. Notify the physician. Notify the resident's responsible party. Complete an incident report and notify the licensing agency per requirement. The facility's Missing Person - When Resident Returns to Community policy (undated), documented the facility would obtain an updated medical evaluation from the hospital or doctor's office. Maintain resident behavior monitoring for identification of any triggers. Complete resident record documentation. Update service plan and resident summary to reflect potential elopement. Severity: 2 Scope: 1 Complaint #NV00071822			

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0991 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: (b) Operational alarms, buzzers, horns or other technology for notifying staff 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 exit doors sounded an audible alarm upon opening. Findings include: On 08/07/24 at 8:40 AM, the alarm on the facility's front door was not audible. On 08/07/24 at 9:25 AM, the alarm on the facility's patio door was not audible. On 08/07/24 at 9:30 AM, the Manager reported it was a small home and the alarms were turned on sometimes, but not all of the time. The Manager acknowledged knowing the alarms should have been audible at all times. Severity: 2 Scope: 3 Complaint #NV00071822	0991	1. WE CORRECTED THIS FINDING BY HAVING A TRAINING ON DOOR ALARMS AND THE IMPORTANCE OF THEM WITH THE STAFF. 2. DAILY WE WILL MAKE SURE THE GATES ARE LOCKED AND THE DOORS ARE ALARMED. 3. DAILY WE MONITOR THAT THE GATES ARE LOCKED AND THE DOORS ARE ALARMED. 4. THE SUPERVISOR WILL MONITOR THE GATES AND DOORS DAILY AND WEEKLY THE OWNER WILL MONITOR THE GATES ARE LOCKED AND THE DOORS ARE ALARMED. 5. AUGUST 4 2024 THIS WAS CORRECTED AND THE TRAINING WAS COMPLETED. 6. SEE ATTACHED TRAINING 7. WE WILL MONITOR THE DOORS AND ALARMS DAILY BY THE SUPERVISORS AND WEEKLY BY THE OWNER AND ADMINISTRATOR TO ENSURE THIS CORRECTIVE ACTION DOES NOT RECUR.	08/04/2024

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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 the three gates of the facility leading to the street were locked. Findings include: On 08/07/24 at 9:45 AM, the back yard gate on the east side of the house was unlocked. The back yard gate to the west side of the house was unlocked. The side gate that led to a second unlocked gate on the side of the house was unlocked. The gates on one side of the house led to an open area and to the street in front of the facility. The gates on the other side of the house let to the driveway and to the street in front of the facility. On 08/07/24 at 9:45 AM, the Manager acknowledged the three gates were unlocked and reported knowing they should have been locked. Severity: 2 Scope: 3 Complaint #NV00071822	0995	1. WE WILL PREVENT THIS FROM OCCURING BY New locks were purchased FOR DOORS and NEW LOCKS WERE installed for the gates. 2. Routine DAILY checks of gates LOCKED, and all staff retrained on locking and unlocking gate policies and procedures. 3. Routine monthly and weekly checks of gates BY OWNER, and routine interview of staff. Staff will check LOCKS at beginning of shift. 4. Administrator, owner, manager WILL BE OVER SEEING GATES BEING LOCKED AND SECURE. 5. 8/8/2024 6. RECEIPT OF LOCKS ADDED AND PLACED ON GATES. 7. LOCKS AND ALARMS ARE CHECKED DAILY BY SUPERVISOR AND MONTHLY BY OWNER TO ENSURE THIS DEFICIENT PRACTICE WILL NOT RECUR.	08/08/2024