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
	7273	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROYAL PLACE, INC	3644 MOUNTCREST DRIVE, LAS VEGAS, NEVADA ,89121

(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 an annual state licensure and infection control survey conducted at your facility on 04/29/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly/disabled persons and/or persons with chronic illness, and/or persons with mental illness, Category II residents. The census at the time of the survey was seven. Seven resident files and five employee files were reviewed. The facility received a grade of A. 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		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JOANNE MISURACA Title: Administrator Date: 05/11/2021

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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 observation, interview, and document review the facility failed to implement safe infection control practices for the protection of residents and staff in response to the COVID-19 Pandemic. Findings include: On 04/29/21 in the afternoon, the Health Facilities Inspector (HFI) arrived at the facility and was not asked questions to screen for COVID-19 symptoms prior to being allowed to enter the facility. Two healthcare providers were observed entering the facility and were not asked COVID-19 screening questions prior to entry. Review of the facility's COVID-19 infection control policy revealed the following: Visitors must attest they are free of any symptoms of COVID-19. A COVID-19 Screening Questionnaire will be completed and filed by the staff for each visitor. On 4/29/21 in the afternoon, the Manager acknowledged all visitors should be asked COVID-19 screening questions prior to entry. Severity: 2 Scope: 3	0050	Tag 0050 1. We have discussed with our staff they must implement safe infection control practices for the protection of residents and staff in response to the Covid 19 Pandemic. The staff will ask the questions on the Covid 19 questionnaire we have. (See Attachment) 2. A Covid 19 Screening Questionnaire will be completed for each visitor and filed by the staff in binder. 3. The Administrator will check the binder to ensure each visitor has a Covid 19 Questionnaire. This will ensure deficient practice does not recur. 4. The Administrator will be responsible for ensuring the plan of correction is implemented. 5. Date of Compliance: 5/1/21	05/01/2021