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
	7699	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY CARE HOME, LLC	**3740 LA JUNTA DRIVE, LAS VEGAS, NEVADA ,89120**

(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 State Licensure annual and infection control survey conducted at your facility on 12/15/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illness and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Seven resident files and four 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 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		

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0936 SS= D	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure an annual tuberculosis (TB) test was completed for 1 of 7 residents (Resident #1 was admitted on 08/06/21, last documented TB test was completed on 08/03/21). The Administrator acknowledged an annual TB test was not completed. Severity: 2 Scope: 1	0936	Y 0936 1. The administrator of the facility has established a separate file for each resident of the facility and the files will be kept locked and protected against unauthorized use. The administrator has evidence of documentations for all the resident's step 1 & step 2 TB records including annual TB testing. Resident # 1 has documented evidence of annual TB testing done on 12/15/22 (see attachment) 2. The administrator has a systematic change in place to ensure the deficient practice does not recur. The administrator will review weekly to ensure that all TB testing step 1, step2 and annual TB testing is completed and documented. 3. The administrator will monitor to ensure that the deficient practice will not recur therefore, on a weekly basis the administrator will review all resident' files to ensure that TB step 1, step 2 and annual testing is completed to comply with regulations. 4. The administrator of the facility will be responsible for ensuring the plan of correction is implemented. 5. The corrective action completed on 12/15/2022	12/15/2022

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0991 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: (b) Operational alarms, buzzers, horns or other audible devices which are activated 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 alarms were operational on exit doors as evidenced by: The alarm on the sliding glass door in the kitchen was turned off and did not chime when opened. The door leading to the outside patio in the Caregiver's room was not alarmed and the bedroom door did not have a functioning lock on it to prevent access to the exit door. The Caregiver acknowledged the alarm was turned off on the sliding glass door and should have been turned on. The Administrator acknowledged the Caregiver's bedroom door did not lock and the exit to the patio was not alarmed. Severity: 2 Scope: 3	0991	Y 0991 1. The administrator of the facility will ensure doors that can be used to exit the facility will have alarms and the alarms must kept turned On and operating properly. The door leading to the outside patio in the caregiver's room has an alarm now and the alarm is turned on at all times and it's functioning properly. The alarm on the sliding glass door in the kitchen area was turned on 12/15/2022, and its operational now. 2. The administrator will monitor weekly by walking through the facility to ensure that all the facility doors used to exit the facility has an alarm and the alarm is turn on and it's functioning properly to ensure the deficient practice does not recur. 3. The administrator will monitor to ensure that this deficient practice will not recur. On a weekly basis, the administrator will walk through the facility exit doors to ensure that the alarms are turn on and functioning properly to comply with the regulations 4. The administrator of the facility will be responsible for ensuring the plan of correction is implemented. 5. The corrective action was completed on 12/16/2022	12/16/2022