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 _____	**12/20/2023**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted at your facility on 12/11/23 and completed on 12/20/23, 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 chronic illness, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Nine resident files and five employee files were reviewed. The facility received a grade of B. There was one complaint investigated: 1. Complaint #NV00069998 was verified. (See Tag 860) The investigation of the Complaint included: Observation of resident physical appearance, fall precations and interventions, staff monitoring residents and a tour of the facility. Interviews were conducted with the residents, two Caregivers, the resident of concern's spouse, and the Administrator. Record review of nine resident records, including the resident of concern. Document review included facility policies and procedures and facility 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 deficiences were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NANA GYEABOUR Title: Administrator Date: 01/19/2024

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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0276 SS= F	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation and interview, the facility failed to ensure food was not expired and was suitable for residents. Findings include: On 12/11/23 in the morning, the following was observed: - A bottle of salad dressing which expired on 07/18/23 in the kitchen refrigerator. - A bottle of spaghetti sauce which expired on 10/24/23 in the kitchen refrigerator. - A gallon of milk which expired 12/09/23 in the kitchen refrigerator. - A bottle of garlic hummus which expired on 11/25/23 in the kitchen refrigerator. - A container of parmesan cheese which expired on 01/13/23 in the kitchen pantry. - A container of brown gravy mix which expired on 01/03/23 in the kitchen pantry. On 12/11/23 in the morning, the Caregiver acknowledged the expired food and indicated it was not suitable for residents. Severity: 2 Scope: 3	0276	Y0276 1. The facility administrator and the caregivers will ensure that all can foods and other food items in the refrigerator are checked weekly for expiration dates and meals are nutritious, and served in an appropriate manner, suitable for the residents. All expired foods including a bottle of salad dressing in the refrigerator, a bottle of spaghetti, a gallon of mild, a bottle of garlic hummus, a container of parmesan cheese and a container of brown gravy mix, were thrown out in the garbage and replaced them with new items with the right and current dates. In addition, the facility will ensure that all food items purchased from the supermarket on a weekly basis, will have current dates and years on them. 2. The deficient practice will not recur. On a weekly basis, the administrator will check all food items in the refrigerator and in the pantry including all can foods to ensure that all the food items have current date and year. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. the caregivers will check prior to preparing meals to ensure that all the food items have current date and year. 4. The administrator of the facility and the caregivers will be responsible for ensuring the plan of correction is implemented. 5. The corrective action was completed on 12/12/2023	12/12/2023
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on interview	0515	Y0515 1. The administrator of the facility has developed a person-centered service plan for the 6 residents who are currently living in the facility and any future residents who may move into the facility. In addition, the administrator has implemented a person-centered service plan for each resident and placed them in their files as part of the	12/13/2023

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	and record review, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7 and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/04/17, with diagnoses including heart failure and Alzheimer's disease. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 11/22/23, with diagnoses including Alzheimer's disease and diabetes. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on 09/24/19, with diagnoses including Alzheimer's disease and hypertension. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 01/25/20, with diagnoses including cerebral vascular incident and heart disease. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 09/11/23, with diagnoses including dementia and uterine cancer. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 08/06/21, with diagnoses including Parkinson's disease and aortic valve disorder. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 05/11/23, with diagnoses including dementia and hypertension. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted to the facility on 11/14/23, with a diagnosis of senile degeneration of the brain. R8's file lacked a person-centered service plan. On 12/11/23 in the afternoon, the Administrator acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7 and R8. Severity: 2 Scope: 3		record. Resident #1, #3, #4, # 5, #6, #7. All these residents now have a person-centered service plan in their files. Resident # 2, and #8, passed away, no longer lives here. 2. The deficient practice will not recur. The facility administrator will provide a person-centered service plan during the admission process when the resident moves in to ensure that all the residents needs are met. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. Currently, most of the residents are under hospice care, and the agency provides the facility a person-centered service plan for each of the residents and the agency instruct the facility to follow such orders. The facility and the hospice agency will work together to maintain a service plan that works best for the resident. Also, on a monthly basis, the administrator will review all the residents' files to ensure that the residents have a person-centered service plan in their files and 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 12/13/2023	
1010 SS= D	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	1010	Y 1010 1. The administrator will ensure that prior to admitting any resident in the facility, the resident will not have mental illness diagnosis because the facility endorsement does not allow such resident to be admitted.	12/15/2023

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	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. 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 and record review, the facility failed to ensure the facility obtained a mental illness endorsement to care for a resident with mental illness for 1 of 9 sampled residents. (Resident #9) Findings include: Resident #9 (R9) R9 was admitted to the facility on 11/28/23 with a diagnosis of bipolar, post-traumatic stress disorder and metabolic encephalopathy. A Discharge Summary dated 11/28/23 documented the resident had metabolic encephalopathy. The Discharge Summary documented R9 had to be in an enclosure bed because R9 was pushing on the sides of the enclosure bed in an attempt to get out. The summary documented R9 was banging on the sides of the enclosure bed and was combative and impulsive the entire time. R9 was not able to follow one step commands. Additional staff were summoned to assist getting R9 back into R9's fully enclosed bed. A Nurse Practitioner Attestation of Encounter dated 11/29/23 documented the resident had senile degeneration of the brain with comorbidities of bipolar, post-traumatic stress disorder and dementia. On 12/20/23 in the morning, E3 verbalized R9's need for constant supervision, and indicated the facility had monitored R9 around the clock since the time of admission because the resident required supervision for aggressive/combative behaviors. E3 reported R9 was combative, hit the wall and was unable to be redirected. E3 acknowledged staff were not able to control R9's behavior and that R9 would		The resident no longer resides at the facility. 2. The administrator will ensure that the deficient practice does not recur. Prior to admission of any new resident to the facility, the administrator will ensure that the resident does not have mental illness diagnosis. 3. The administrator will monitor and ensure that the deficient practice will not recur. The administrator will review monthly and any new admission to ensure that the resident does not have mental illness. The facility will comply with the regulations during standard assessment/evaluation of new residents. 4. The administrator of the facility will be responsible for ensuring the plan of correction is implemented. 5. The corrective action was completed on 12/15/2023	

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	attempt to strike or elbow staff members. On 12/20/23 in the morning, the Administrator reported assessing R9 on 11/27/23 and observed R9's was lying in an enclosed bed. The Administrator did not question the facility regarding why R9 was lying in an enclosed bed. The Administrator reported being unaware of why R9 was in an enclosure and acknowledged not asking more questions about R9's diagnosis prior to R9's admission. The Administrator acknowledged R9 was not appropriate for the facility because the facility did not have a mental illness endorsement and R9 had documented mental illnesses, and should not have been admitted. Severity: 2 Scope: 1 Complaint #NV00069998			

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1830 SS= E	Infection Control Required Training Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control designees acquired the required 15 hours of infection control training. Findings include: On 12/11/23 in the afternoon, the records for E3 and E5, the primary and secondary infection control designees respectively, lacked documented evidence of 15 hours of training concerning the control and prevention of infections from the approved nationally recognized organizations. On 12/11/23 in the afternoon, the Administrator confirmed the 15 hours of required infection control and prevention training had not been completed for the primary and secondary infection control designees, E3 and E5. Severity: 2 Scope: 2	1830	Y 1830 1. The administrator of the facility will ensure that the primary and secondary infection control designees have the 15 hours of infection control training. E3 and E5, the primary and secondary infection control designees respectively, now have documented evidence of 15 hours of infection control training concerning the control and prevention of infections. 2. The administrator will put in place this measure to ensure the deficient practice does not recur. The administrator will review the primary and secondary infection control designees' records to ensure that they meet all the requirements - 15 hours of training. 3. The corrective action will be monitored to ensure the deficient practice will not recur. On a monthly basis, the administrator will review the primary and secondary infection control designees' records to ensure they received the 15 hours training, and the facility will 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 10/26/23	10/26/2023