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 _____	**12/10/2024**

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 and a complaint investigation survey initiated at your facility on 12/10/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine 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 nine. Nine resident files and four employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Unsubstantiated: Complaint # NV00072394 could not be substantiated. The investigation of the complaint included: Observations of residents, caregivers, and the environment. Interviews with residents, caregivers, and the Administrator. Record review of five resident records, including the resident of concern. Document review of facility policies, incident reports, and employee training. The following regulatory deficiencies were identified:	0000		
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure the facility's interior and exterior were well maintained and hazards were properly secured from residents. Findings include: On 12/10/2024 in the morning, the following observations were made on the exterior of the facility. 1. The door and the door latch to the storage shed was not properly maintained and was unsecured. Inside the	0178	Y 0178 1. The administrator will ensure that the facility interior and exterior is well maintained, and the premises clean including the landscaping and hazards properly secured from all the residents. In addition, the facility administrator has removed multiple unused appliances from the patio area and stored them in the storage shed. (a) The door and the door latch to the storage shed is repaired and secured with a lock key. Inside the shed is well organized and put away all the unnecessary items. (b) Unused hospital bed, including extra tiles for the roof is removed and stored in the storage shed. (c) In the interior of the facility, around room #6, a loose ceramic floor tile repaired and	01/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NANA GYEABOUR Title: Administrator Date: 01/29/2025

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	storage shed were the following items of concern: - Three cans of paint - Oxygen E-tanks, one unsecured by the entrance, three unsecured towards the back of the shed and three in individual carts - One large container of liquid laundry detergent 2. Stored in the resident patio area were the following items: - A washing machine which was unplugged and not being used - An unlocked filing cabinet - An empty mop and bucket 3. On the perimeter of the back yard were the following: - A hospital bed not in use - A soiled pillow without a pillowcase left at the base of one of the palm trees - Extra tiles for the roof - A fireplace grate 4. On the front exterior of the facility, a retaining wall in the corner of the front yard was in need of repair. The wall blocks had collapsed which compromised the stability of the plant bed. The plant bed and soil base were spilling into the public walkway. On 12/10/2024 in the morning, the following observations were made on the interior of the facility. 5. In the hallway by resident room #6 was a loose ceramic floor tile creating a tripping hazard. 6. The hand sink in the bathroom by resident room #4 was in need of repair. The hand sink faucet was observed to have a constant slow water leak. The faucet handles were turned on and off to test if the slow leak would be remedied but the water leak remained. The staff were unaware of how long the slow leak had been flowing. 7. The vent cover and filter outside of resident room #5 were covered with dust. 8. The shower stall in the bathroom by resident room #5 was in need of maintenance as evidenced by an unknown black substance on the shower stall's surface. 9. The built-in drawers between the dining room and kitchen were unsecured. The safety latches were not in working order. In two out of four drawers, were four pairs of scissors and push-pins. The caregivers were made aware of the findings as they were discovered. The caregivers were unaware of the repairs needed and the hazards present throughout		secured. The hand sink leak in the bathroom by resident room # 4, and the faucet is repaired as well. (d) The vent cover and filter outside room # 5 is cleaned. Finally, the shower stall fixed and secured. The built-in drawers between the dining room and the kitchen are secured with lock keys. 2. The deficient practice does not recur. on a daily basis, the administrator will monitor and ensure that the facility's interior and exterior are well maintained, and hazards are properly secured from residents. The facility will comply with all regulations. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. The facility administrator will ensure that each resident of the facility is secured and free from any hazards. Also, the administrator will make sure the premises is clean and the interior and exterior including landscaping are maintained. 4. The facility administrator will be responsible for ensuring the plan of correction implementation. 5. The corrective action was completed on 01/20/2025	

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	the exterior and interior of the facility. The caregivers acknowledged the findings and indicated they would notify the Administrator of the repairs needed and hazards to be secured. Severity: 2 Scope: 3			
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on interview and record review, the facility failed to ensure six-month Medication Reviews were reviewed, initialed and dated by the Administrator within 72 hours for 3 of 9 residents (Residents #4, #6, #7). Findings include: Resident #4 R4 was admitted on 01/25/2020 with diagnoses of cerebral infarction and Dementia. R4's file documented medication reviews dated 06/01/2023 and 06/28/2024. The reviews lacked the initials of the Administrator and date of review. Resident #6 R6 was admitted on 08/06/2021 with diagnoses of aortic valve sclerosis and Parkinson's Disease. Review of R6's file documented medication reviews dated 06/01/2023 and 06/28/2024. The reviews lacked the initials of the Administrator and date of review. Resident #7 R7 was admitted on 09/24/2019 with a diagnosis of Myotonic Muscular Dystrophy, congestive heart failure, hypertension, unspecified fracture of the lower end of left radius and Alzheimer's Disease. R7's file documented medication reviews dated 06/01/2023 and 06/28/2024. The review lacked the initials of the Administrator and date of review. On	0874	Y 0874 1. The administrator of the facility has reviewed and corrected the quarterly medication reviews for residents # 4, residents #6, and residents #7, and made an adjustment and reconciled the differences and updated records including documented evidence of the review and the administrator's initials as required by regulations. Resident# 4, have a new medication review form updated and shown the right dates. The updated review record showed: 6/1/23 to 12/1/23 and then, 6/28/24 to 12/28/24 Resident# 6, have a new medication review form updated and shown the right dates. The updated review should have been: 6/1/23 to 12/1/23 and then, 6/28/24 to 12/28/24 Resident# 7, have a new medication review form updated and shown the right dates. The updated review should have been: 6/1/23 to 12/1/23 and then, 6/28/24 to 12/28/24 2. The deficient practice does not recur. On a weekly basis, the facility administrator will review all the residents MAR to ensure all the residents have documented evidence of quarterly medication review by a physician or nurse practitioner and the report will have the facility administrator initials on the report as well as part of the regulations. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. The administrator will ensure that all the residents MAR are reviewed for accuracy and the administrator's initials will be part of the report.	12/19/2024

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	12/10/24 in the afternoon, the Administrator acknowledged the six-month Medication Reviews should have been initialed and dated by the Administrator within 72 hours. Severity: 2 Scope: 2		4. The facility administrator will be responsible for ensuring the plan of correction is implemented 5. The corrective action was completed on 12/19/24	

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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 have the keys for the locks on the exterior gate readily available for the facility staff members at all times. Findings include: On 12/10/2024 in the morning, a tour of the facility's exterior revealed the exit gate leading to the outside public way area had two pad locks to secure the outdoor activity area. Each pad lock had a separate key. The caregivers did not know where both keys were kept and both keys were not readily available for all staff members. This gate was the only means of egress from the exterior activity area should the residents need to exit for safety to the outside of the facility. The gate led to the front driveway and to the street providing a means to an exterior area of refuge. On 12/10/2024 in the afternoon, the Administrator acknowledged the findings and indicated they did not have the keys for both pad locks. Severity: 2 Scope: 3	0995	Y 0995 1. The administrator have provided a pad lock to secure the outdoor gate leading to outside the public way to the street. The gate has one key readily available for the staff members to use when the residents will need to exit for safety to the outside of the facility. 2. The deficient practice does not recur. On a daily basis, the administrator will monitor and walk through the facility to ensure that all the exit doors including gates are secured and the facility caregivers will have a key to unlock the gate in case of an emergency. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. The administrator will comply with the regulations and the caregivers will have always a key to the exterior gate readily available at all times. 4. The administrator of the facility will be responsible for ensuring the plan of correction is implemented. 5. The corrective action was completed on 12/11/24	12/11/2024

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1036 SS= E	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. Inspector Comments: Based on interview and record review, the facility failed to ensure 2 of 4 employees received an additional 8 hours of Tier 2 Alzheimer's/Dementia training within 3 months of employment (Employees #1 and #2). Findings include: Employee #1 (E1) E1 was hired on 03/24/24 as a Caregiver. E1 received 10 hours of Alzheimer's Disease/Dementia training on 03/24/24. The certificate of completion of training in E1's file lacked documented evidence of Tier 2 training. Employee #2 (E2) E2 was hired on 02/27/24 as a Caregiver. E2 received 10 hours of Alzheimer's Disease/Dementia training on 03/24/24. The certificate of completion of training in E2's file lacked documented evidence of Tier 2 training. On 12/10/24 in the afternoon, the Administrator acknowledged the Alzheimer's/Dementia training certificates in E1 and E2's files did not document the topics covered in the Tier 2 training. Severity: 2 Scope: 2	1036	Y 1036 1. The facility administrator will provide employee# 1, and employee# 2, with Alzheimer's/Dementia trainings. The administrator has also scheduled online training sessions for both employees. Employee#1 and Employee#2 NO LONGER WORKS HERE. Employee # 1, quit her job, and employee# 2 was terminated. Employee# 1, and Employee# 2, are scheduled to have Alzheimer's/Dementia Tier 2 trainings very soon and the administrator will provide documented evidence upon completion of this training. 2. The deficient practice does not recur. The administrator will ensure that within 3 months after initially employed, the employee will have at least 8 hours of tier 2 Alzheimer's/Dementia training and obtained a certificate completion, and the topics covered in the tier 2 training. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. The administrator will ensure that the facility caregiver's providing care to the patients have the proper training needed to do their work, and they will receive the requirements, and the facility will comply with this regulation NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia. 4. The facility administrator and the caregiver's will be responsible for ensuring the plan of correction is implemented. 5. The corrective action will be completed in a future date 1/30/25	01/30/2025
1037 SS= E	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility	1037	Y 1037 1. The administrator will provide all the	01/30/2025

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	which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 4 employees received annually 3 hours of Tier 2 Alzheimer's/Dementia training (Employees #3 and #4). Findings include: Employee #3 (E3) E3 was hired on 01/10/14 as a Caregiver/Medication Technician. E3 received 10 hours of Alzheimer's Disease/Dementia training on 03/24/24. The certificate of completion of		employees with annual 3 hours of tier 2 Alzheimer's/Dementia training, as per current regulations. Employee# 3, and Employee#4, will be receiving tier 2, on Alzheimer's/Dementia and the employees will have documented evidence of the training and the topics covered in the tier 2 training. Employee#3, and Employee #4 have received the required trainings for tier 2 Alzheimer's/Dementia trainings. 2. The deficient practice does not recur. On a monthly basis, and upon new hired employees, the administrator will ensure that existing and newly hired employees will have evidence and documented training for tier 2 Alzheimer's/Dementia and a certificate of completion with the topics covered in tier2 training. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. The administrator will ensure that every employee has documented evidence of initial tier 1 and annual tier 2 with 3-hours training. The facility will comply with regulations. 4. The administrator of the facility will be responsible for ensuring the plan of correction is implemented. 5. The corrective action will be corrected on 1/30/25. Training scheduled	

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	training in E3's file lacked documented evidence of Tier 2 training. Employee #4 (E4) E4 was hired on 09/18/14 as the Administrator. E4 received 3 hours of Alzheimer's Disease/Dementia training on 03/24/24. The certificate of completion of training in E4's file lacked documented evidence of Tier 2 training. On 12/10/24 in the afternoon, the Administrator acknowledged the Alzheimer's/Dementia training certificates in E3 and E4's files did not document the topics covered in the Tier 2 training. Severity: 2 Scope: 2			

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview, record review and document review the facility failed to ensure a background check was completed through the Nevada Automated Background Check System (NABS) for 1 of 4 employees (Employee #1). Findings include: Employee #1 (E1) E1 was hired on 03/24/24 as a Caregiver. A letter in E1's file from the Nevada Department of Public Safety documented E1's fingerprint card dated 07/31/24 had not been returned. Fingerprinting was not completed within 10 days of hire. E1's file lacked documented evidence the facility had resubmitted the fingerprint card and followed up on the background check. On 12/10/24 in the afternoon, the Administrator acknowledged E1 did not have a completed background check and had continued to work as a caregiver at the facility. Severity: 2 Scope: 1	0104	Y0104 1. The administrator will ensure that E1, receives a new set of fingerprints background check from Automated Background Check System (NABS). E1, have resubmitted a new set of fingerprints to department of public safety to complete the process. The facility administrator will follow through with the NABS, to have documented evidence of background check and a clearance letter. EMPLOYEE # 1 DECIDED TO QUIT HER JOB ON 1/29/25 2. The deficient practice does not recur. The administrator will ensure that newly and existing employees will all receive within 10 days of employment, fingerprints background checks are completed and file them in their personnel records. 3. The corrective action will be monitored to ensure that the deficient practice will not recur. The administrator on a monthly basis will review all the employee's records to ensure the accuracy of background checks including the documented evidence and a clearance letter from NABS. The facility will comply with the regulations NAC 449.200 Personnel files. NRS 449.0302. 4. The facility administrator will be responsible for ensuring the plan of correction is implemented. 5. Corrective action will be completed on 1/30/25.	01/30/2025