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
	8089	A. BUILDING _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JEREMIAH CARE HOME	3918 CHEROKEE AVENUE, LAS VEGAS, NEVADA ,89121

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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 08/24/22, 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 persons with Alzheimer's disease, Category II residents. The census at the time of survey was nine. Nine resident files and three 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: ERNIE M DIAZ Title: ADMINISTRATOR Date: 09/14/2022

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0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure 2 of 9 sampled residents were free from the use of restraints (Resident #5 and #6). Findings include: Resident #5 (R5) R5 was admitted to the facility on 07/29/22, with diagnoses including diabetes and pneumonia. On 08/24/22 at 9:00 AM, R5 was observed lying in bed with one half-length bedrail up on one side. The other side of R5's bed was pushed up against the wall. R5 was unable to answer interview questions and could not demonstrate the ability to lower the bedrail independently when requested. The Caregiver acknowledged R5 was not able to lower the half-length bedrail independently. The Caregiver indicated R5 needed the bedrail for R5's protection and safety. Resident #6 (R6) R6 was admitted to the facility on 12/07/20, with diagnoses including diabetes and falls. R6 was observed lying in bed with two half-length bedrails on either side of the bed. R6 verbalized R6 was unable to lower the bedrails independently without assistance from Caregivers. The Caregiver acknowledged R6 was not able to lower the half-length bedrails independently. Severity: 2 Scope: 1	0557	1. On 8/27/22 both half-length bedrails on resident 5's bed and resident 6's bed were removed. 2. Will not allow the use of bedrails whether full or half-length on any of resident's beds. 3. Administrator, Owner and all Caregiver's have been notified not to allow any kind of bedrails to be used for any residents. 4. Administrator is ultimately responsible that no bedrails will be used. 5. Bedrails were removed on 8/27/22. 6. Please see attached document for resident #6. Did not include document for resident #5 due to death.	09/14/2022

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0876 SS= E	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 9 sampled residents had an ultimate user agreement (Residents #7, #8 and #9). The Medication Technician was unable to provide the missing documentation. Severity: 2 Scope: 2	0876	1. The Ultimate User Agreements for resident's #7, #8 and #9 were actually in their respective folders, just not located in the correct tabs. 2. Administrator and Owner will ensure all documents required for admission is completely filled out and placed correctly in the resident's folder. 3. Administrator will do a monthly check of resident's folders to ensure that all documents are correctly placed in the resident's folder. 4. The Administrator is ultimately responsible that all documents are properly placed and complete in each resident's folder. 5. On 8/27/22 Administrator located all Ultimate User Agreements for resident #7, #8 and #9. 6. Please see all attached documents.	09/14/2022

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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 interview and record review, the facility failed to ensure 1 of 9 sampled residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 06/04/22, with diagnoses including chronic kidney disease and blurred vision. R1's file documented a one-step TB test completed on 07/17/22. R1's file lacked documented evidence an initial two-step TB test was completed. On 08/24/22 at 10:30 AM, the Caregiver acknowledged R1's initial two-step TB test had not been completed. Severity: 2 Scope: 1 Repeat Deficiency from the 09/24/21 inspection	0936	1. On 8/26/22 a 1st Step TB test was initiated and read negative on 8/28/22. Then a 2nd Step was initiated on 9/2/22 and read negative on 9/4/22 for resident #1. 2. A New Resident Checklist was placed in each Prospective New Resident's folder to remind all staff what documents are required to be in compliance. 3. Administrator and Owner will ensure that a 2 Step TB Test is always done on New Residents. 4. Administrator is ultimately responsible that all documents for all new residents are complete and correctly placed in each resident's folder. 5. 1st and 2nd Steps were initiated on 8/26/22 and 9/2/22 and both read as negative on 8/28/22 and 9/4/22. 6. Please see attached documents.	09/14/2022

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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 an audible alarm system was activated on 2 of 4 doors exiting the facility. Findings include: On 08/24/22, at 9:00 AM, the audible alarm system on two exit doors, leading to the backyard did not activate when opened. The Caregiver acknowledged the exit doors' alarms were turned off; and the exit doors did not sound when opened. Severity: 2 Scope: 3 Repeat Deficiency from the 09/24/21 inspection.	0991	1. Immediately after the Survey on 8/24/22, both alarms were turned on. 2. A reminder to never turn off alarms was placed on all doors with alarm systems in place. 3. First thing in the morning, Lead Caregiver will check and monitor that all alarms are properly working. 4. Administrator is ultimately responsible that all Caregiver's do their part in not allowing alarms to be turned off by anyone. 5. Immediately after the survey on 8/24/22, both alarms that were turned off was turned on and also checked that other 2 alarms were also turned on and in good working condition. 6. Please see attached documents.	09/14/2022