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
	8317	A. BUILDING _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADULT COMFORT AND CARE HOME 2	10315 QUEENSBURY AVENUE, LAS VEGAS, NEVADA ,89135

(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 survey initiated at your facility on 08/29/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 10 Residential Facility for Group beds for persons with mental illness, individuals with intellectual disabilities and/or persons with chronic illness, Category II residents. The census at the time of the survey was nine. Nine resident files were reviewed and seven 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 deficiency was identified.	0000		
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical	0690	1. How you will correct the specific finding(s) stated in the Statement of Deficiencies **On August 29th 2019, when the inspector informed the administrator that the oxygen tanks have to be secured, Administrator ordered the cannister holders and placed the oxygen cannisters in the cannister holders.** 2.What measure or systemic changes will be put into practice to ensure the deficient practice does not reoccur. **Administrator has informed Oxygen suppliers that whenever they deliver any portable oxygen cannisters, they have to deliver a cannister holder too.** 3. How the corrective actions will be monitored to ensure the deficient	09/06/2019

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: KARPAL PANNU Title: ADMINISTRATOR Date: 09/09/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8317	A. BUILDING _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADULT COMFORT AND CARE HOME 2	10315 QUEENSBURY AVENUE, LAS VEGAS, NEVADA ,89135

(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
	equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview the facility failed to ensure Oxygen canisters were properly stored for 1 of 9 residents (Resident #1). Findings include: Resident #1 (R1) was admitted on 06/26/19 with diagnosis including hypertension and senile degeneration of the brain. On 08/29/19 at 9:12 AM, there were six Oxygen (O2) canisters in R1's closet which were not secured to the wall or in a canister holder. On 08/29/19 at 2:00 PM, the Administrator confirmed the O2 canisters in the closet of R1 were not properly secured. Severity: 2 Scope: 1		practice will not reoccur. **Administrator and staff will ensure that whenever any portable oxygen cannisters are delivered, they will be securely stored in a cannister holder.** 4. The title of the person responsible for ensuring the plan of corrections is implemented. **Administrator implemented the correction within 24 hours of being notified of the deficiency and on August 30th, 2019 Administrator emailed a picture of the cannisters in a cannister holder to the inspector. (picture attached in POC)**	