

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>8455</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/24/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CASA OLIVA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3209 CEDAR STREET, LAS VEGAS, NEVADA ,89104</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                       | <p>Initial Comments</p> <p>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 10/24/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine beds for persons with persons with mental illness and/or chronic illness and or intellectual disabilities, five Category I and four Category II residents. The census at the time of survey was nine. Nine 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 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.</p> |                                                                                                 |                                                                                                                          |                                                        |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>8455</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/24/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CASA OLIVA</b>    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3209 CEDAR STREET, LAS VEGAS, NEVADA ,89104</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0938<br/>SS= D</b> | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG<br><br><b>0938</b>                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X5)<br>COMPLETION<br>DATE<br><br><b>10/25/2022</b>    |
|                                                          | <p>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: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year.</p> <p>Inspector Comments: Based on interview and record review, the facility failed to ensure a Standard Placement determination to allow a resident with an Alzheimer's disease to remain in the facility was completed annually for 1 of 9 residents (Resident #6). Resident #6 (R6) was admitted on 08/29/19 with diagnosis of Alzheimer's disease. A Standard Placement for R6 was last completed on 08/27/19. A Program Service Specialist acknowledged R6 had a diagnosis of Alzheimer's disease and had no Standard Placement evaluation from a physician since 08/27/19. Severity: 2 Scope: 1</p> |                                                                                                 | <p>1) Individual was seen by his PCP on 10/25/2022. PCP revised placement determination and provided documentation for his record regarding appropriateness for residential facility providing care to persons with mental retardation; an endorsement that we do possess at this community</p> <p>2) All new admission paperwork will be processed through the Administrator to assure that required documents are present and completed in accordance with our admissions standards.</p> <p>3) Site Supervisor will provide immediate evaluation of all documentation that accompanies new move in to ensure that it meets regulations. Administrator will complete random sample quality inspections of resident files to ensure that documentation is present and that it is completed according to regulations.</p> <p>4) Site Supervisor and Program Administrator</p> <p>5) 10/25/2022</p> <p>6) Revised Placement Determination and Document from PCP Attached</p> <p>7) Site Supervisor will provide immediate evaluation of all documentation that accompanies new move in to ensure that it meets regulations. Administrator will complete random sample quality inspections of resident files to ensure that documentation is present and that it is completed according to regulations.</p> |                                                        |