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
	8548	A. BUILDING _____ B. WING _____	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUIL BREEZES CARE HOME, LLC	237 PALMETTO POINTE DRIVE, HENDERSON, NEVADA ,89012

(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 and infection control survey conducted at your facility on 05/05/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly/disabled persons and/or persons with chronic illness, five Category I and five Category II residents. The census at the time of the survey was ten. Ten resident files and five 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: MARGIE ANTONIO Title: Administrator Date: 05/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8548	A. BUILDING _____ B. WING _____	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUIL BREEZES CARE HOME, LLC	237 PALMETTO POINTE DRIVE, HENDERSON, NEVADA ,89012

(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
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure all medications were stored securely and inaccessible to 10 of 10 residents. Findings include: On 5/04/2021 in the morning, the medication cabinet in the kitchen was observed unlocked, ajar, and was accessible to residents. There were no employees next to the cabinet to prevent residents from accessing the medications. On 05/04/2021 in the morning, the Owner confirmed the medication cabinet was unlocked and should be maintained secured when caregivers are not present at the medication cabinet. Severity: 2 Scope: 3	0920	1. Staff (owner and caregivers) must lock the medicine cabinet always after giving medications. 2. Staff must double check and make sure that the medicine cabinet is locked at all times after giving medications. A reminder sign "PLEASE LOCK THIS MEDICINE CABINET AT ALL TIMES" is placed at the cabinet door. 3. Administrator and owner to remind caregivers to lock the cabinet all the times and to check it is locked. 4. Administrator ensure that all staff are reminded to lock the medication cabinet. 5. Owner locked the cabinet on 5/04/2021 and all the time following after. 6.Attached is a picture of locked medicine cabinet with reminder sign on it. 7. Administrator and staff must always check and make sure that all cabinets need to be locked are locked.	05/17/2021