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 _____	**09/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINY STARS HOME CARE II, LLC	**1032 SILVER CREEK, LAS VEGAS, NEVADA ,89183**

(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, infection control survey and complaint investigation conducted at your facility on 09/28/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for four Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was two. Three resident files and three employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Complaint #NV00066994 with seven allegations was unsubstantiated. Allegation #1 - The facility failed to ensure a resident was engaged in adequate activities was unsubstantiated based on observation of two facility residents engaged in the activities of solving a crossword puzzle and coloring in an adult coloring book, interviews with two residents who indicated they were satisfied with the type and amount of activities they received, interviews with both Caregivers who indicated the Resident Of Concern (ROC) chose to do activities on their personal cellphone and computer. The Activity Calendar for the last 90 days documented the activity schedules revealed the facility provided adequate activities. The Caregivers couldn't recall any previous resident complaining to them about a lack of activities at the facility. Allegation #2 - The facility failed to provide adequate care and supervision to a resident was unsubstantiated based on observation of the care and supervision given to two facility residents for which the Caregivers attended to the residents any time the residents called out for them. Interviews with two residents who reported they were satisfied with the care and supervision they were receiving and indicated they felt comfortable and well taken care of at the facility.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Interviews with both Caregivers indicated they couldn't recall any residents complaining to them about lack of adequate care and supervision. Three resident files, including the ROC, did not reveal any incident reports or grievances regarding lack of adequate care and no reports of injuries due to lack of supervision. Allegation #3 - A resident woke up with a soiled incontinence brief and was covered in their own feces for the second time because the resident was unable to wake up the Caregiver during the night was unsubstantiated based on interviews with two residents who reported they had no trouble getting a Caregiver to take care of them during the night if they called out for assistance, in addition the residents were able to call for assistance from their cellphones. The Changing Log documented the date and time the ROC's brief was changed and included times up to 11:30 PM. The Caregivers reported the resident had an issue with bowel incontinence which was reported to the Power of Attorney and the resident's Nurse Practitioner. Allegation #4 - A resident reported they stay in bed all day and would only leave for doctor's appointments was unsubstantiated based on interviews with two Caregivers who reported the ROC had pain in their shoulder and back, left-sided hemiplegia, and right foot amputation. The ROC would get out of bed only when they felt up to it. According to the Caregivers, it was difficult for the resident to stand or sit for extended periods of time due to their medical conditions. Allegation #5 - The facility does not keep Activities of Daily Living (ADL) Logs or the Plan of Care or any other documentation was unsubstantiated based on review of three resident files, including the ROC. The files documented yearly ADL assessments and all other necessary records required. Interviews with two Caregivers indicated the ROC was being cared for by a Home Health Agency who kept their own records including a Plan of Care and these records			

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	were available upon request. Allegation #6 - A resident's room did not have good temperature control was unsubstantiated based on the resident's room temperature was comfortable at 75 degrees Fahrenheit. Two Caregivers explained they did everything possible to keep the resident comfortable in their room including setting the facility thermostat to 75 degrees Fahrenheit, lending the resident a fan to use while at the facility, keeping the resident's bedroom door either half open or ajar to allow for better air circulation in the room, opening the resident's bedroom window when requested by the resident and offering the resident to change their room which was refused by the resident, claiming they were, "happy with this room." An interview with the current resident occupying that room revealed they were satisfied with the environmental conditions in the room with the facility thermostat set to 75 degrees Fahrenheit. Allegation #7 - The facility fired a bathing aide because they suspected the aide reported to Adult Protective Services was unsubstantiated based on interviews with two Caregivers who reported the resident requested a bath every day and was given a bath every day by the Caregivers. The resident requested her hair to be shampooed every day which was also done by the Caregivers on a daily basis. According to both Caregivers, there was only one instance when a Certified Nursing Assistant (CNA) from the resident's Home Health Agency came to bathe the resident which was right before the resident discharged from the facility. The CNA from the Home Health Agency had current Elder Abuse training and understood they were a mandatory reporter regarding elder abuse. The investigation into the allegations included: Observations of no odors in the facility, comfortable temperatures in the rooms, resident/Caregiver interactions, residents performing activities and Caregivers providing care. Interviews with two residents and two Caregivers. Record			

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	review/clinical record review of three residents, including the Resident Of Concern, review of the last 90 days of facility activity schedules, the Changing Log, ADL assessments and other documents in the files of other residents. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.			