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 _____ | **07/06/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AMETHYST CARE HOME, LLC** | **3702 INTERNET AVENUE, N. LAS VEGAS, NEVADA ,89031** |

| (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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted in your facility on 07/06/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility was licensed as a Residential Facility for Groups for ten elderly or disabled persons with Alzheimer's disease or related dementia, Category II. The census at the time of the survey was nine. Nine resident files and seven employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Complaint #NV00064036 with four allegations was not substantiated. Allegation #1: The staff allowed non-qualified individuals to pass medications to residents was not substantiated based on observations the resident medications were secured in a kitchen cabinet. A review of employee files indicated all staff who pass medication to residents had current Medication Management training certificates. Interviews with three residents who denied receiving medication from non-qualified individuals. Interviews with the Manager who denied non-qualified individuals are permitted to access resident medications. Allegation #2: Residents were dehydrated and not provided sufficient water was not substantiated based on observations the water was connected to all sinks in the bathrooms and kitchen. Observations of glasses of water or water pitchers in resident rooms. Interviews with three residents who indicated they asked Caregivers for water and it was brought to them. Allegation #3: Staff did not treat residents with dignity and respect when transferring resident to a wheelchair was not substantiated based on observations of a Caregiver assisting a resident during a transfer from a wheelchair to the bed. Interviews with two residents who explained | 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: GILBERTO DECASTRO | Title: Administrator | Date: 07/17/2021

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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| | Caregivers treated them with dignity and respect when transferring from bed to a wheelchair. Interviews with a family member of a resident, who indicated the resident was treated with dignity and respect when Caregivers assisted with transfers in and out of bed. Allegation #4: Facility failed to provide assistance to residents who were calling for help was not substantiated based on observations of a Caregiver assisting a resident who yelled out. The Caregiver sat and talked with the resident until the resident calmed down. Observations of call bells at the bedside of residents. Interviews with three residents who explained Caregivers responded when called for assistance. The investigation into the allegations included: Observations of the facility environment, residents, and staff interaction with residents. Review of nine resident files, seven employee files, and Medication Administration Records for all residents. Interviews with three residents, one resident family member, the Manager, and the Administrator. 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 deficiencies were identified: | | | |

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| 0102 SS= D | Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee;<br><br>Inspector Comments: Based on interview and record review, the facility failed to ensure 1 of 7 employees met the requirements concerning tuberculosis (TB) testing. (Employee #4 lacked evidence they had received a positive TB test prior to receiving a chest x-ray). On 07/06/21 in the afternoon, the Administrator acknowledged the employee should have had a documented positive TB test on file prior to receiving a chest x-ray. Severity: 2 Scope: 1 | 0102 | 1. Employee #4 has obtained a Quantiferon TB test.<br>2. To ensure the deficiency does not occur again, an Employee File Checklist will be used.<br>3. The Administrator will monitor compliance during his visits to the facility.<br>4. 7/17/2021. | 07/17/2021 |
| 0999 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: (g) All toxic substances are not accessible to the residents of the facility.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents. Findings include: On 07/06/21 in the morning during a tour of the facility, a door to the bathroom next to the kitchen was observed unlocked. Observed a bottle of tile and glass cleaner unsecured and hanging from a towel rack in the bathroom. The Manager acknowledged the chemicals should have been secured. Severity: 2 Scope: 3 | 0999 | 1. The toxic item has been stored in a locked cabinet.<br>2. A Facility Checklist will be used to ensure the deficiency does not occur again.<br>3. The Administrator will monitor compliance during his visits to the facility.<br>4. 7/17/2021. | 07/17/2021 |