

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2018
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of a annual State Licensure grading survey conducted in your facility on 03/14/18. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was four. Four resident files were reviewed 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 deficiencies were identified:			

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 Name: CRISANTA PASION Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 04/18/2018

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2018
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0936 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 449.2749(1)(e) - Resident file-NRS 441A Tuberculosis - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 residents met the requirements concerning tuberculosis (TB) testing (Resident #1). Findings include: On 03/14/18, a review of the resident files revealed the following: Resident #1 Resident #1 was admitted on 03/07/17. The resident file contained documentation a QuantiFERON-TB Gold test had been completed with a negative result on 02/28/17. The file lacked documented evidence a TB test had been completed in 2018. On 03/14/18 in the morning, Employees #2 and #4 acknowledged the deficiency and was unable to provide the requested documentation. Severity: 2 Scope: 1	ID PREFIX TAG 0936	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1) TB skin test with a positive result was done on 3/20/18 and a succeeding chest X- ray with a negative result was done on 3/22/18. 2)Scheduling to obtain annual TB testing will be initiated timely to ensure completion prior to exceeding one year from last TB test.	(X5) COMPLETION DATE 03/22/201 8

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2018
NAME OF PROVIDER OR SUPPLIER MASTER CARE GROUP HOMES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6562 W. MESA VISTA, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0999 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 449.2756(1)(g) - Alzheimer's Facility-Toxic substances - NAC 449.2756 Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required; training for employees. 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. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to the residents. Findings include: On 02/14/18 at 10:15 AM, a can of Lysol spray was observed on top of a dresser in Resident #4's bedroom. On 02/14/18 at 10:00 AM, Employee #2 acknowledged the observation and reported the spray should have been locked up in the laundry room cabinet. Severity: 2 Scope: 3	ID PREFIX TAG 0999	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1)Caregiver locked aerosol when pointed out by inspector. Administrator reminded caregivers to lock all toxic substances immediately after use. 2)Administrator will check for compliance when visiting the facility.	(X5) COMPLETION DATE 03/14/201 8