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 _____	**12/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHORN JONES MEMORY CARE, LLC	**6017 ELKHORN ROAD, LAS VEGAS, NEVADA ,89131**

(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 a complaint investigation at your facility on 12/02/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 23. The sample size was five. There were four complaints investigated. Complaint#NV00062652 with the allegation a resident was constipated; two employees stimulated the resident's anus with their fingers in order to release a bowel movement was unsubstantiated based on interviews with employees. The resident of concern was unable to be interviewed based on Alzheimer's diagnoses. The investigation into the allegations included: Observations of the resident of concern in the common area, sitting in a wheelchair. Interviews with one Med Tech, three Caregivers, one Executive Director and one Business Office Manager. Document review of Elder Abuse policy and Change in Condition. Review of 5 resident files including residents of concern and four employees' files reviewed. Complaint #NV00062649 with two allegations was unsubstantiated. Allegation #1: Facility administered resident's medications while the resident was lying down in bed was unsubstantiated based on interviews conducted with employees and observations of medication administration. Allegation #2: Resident had scratches on face, hands and legs was unsubstantiated based on interviews conducted with hospice agency Director of Nursing and Registered Nurse. The resident suffered from allergies and itchy skin. The resident's nails needed to be trimmed on a regular basis. Observation of the resident's face had no signs of scratches. The investigation into the allegations included. Observations of residents in common area, caregivers interacting with residents, residents walking	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NICHOLE CROCK Title: Administrator Date: 12/17/2020

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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	around the facility. Interviews with one Med Tech, three Caregivers, one Executive Director, one Business Office Manager, one Director of Nursing and one Registered Nurse. Document review of Change in Condition policy and Elder Abuse policy Review of 5 resident files including residents of concern and four employees' files reviewed. Complaint#NV00062647 with two allegations was substantiated. Allegation #1: Improper incontinence care; facility staff placed two diapers on a resident to avoid changing the resident's diapers every two hours was substantiated based on interviews conducted with employees and an Incident report. Allegation #2: A resident was walking around the facility naked in front of other residents was substantiated without deficiency based on interview with employees. The resident had lost a family member during the pandemic and became depressed. The investigation into the allegations included: Observations of residents and facility environment. Interviews with one Med Tech, three Caregivers, one Executive Director and one Business Office Manager. Document review of Resident Assistant duties to include supervision of residents. Review of 5 resident files including residents of concern and four employees' files reviewed. Complaint #NV00062650 a resident was over-medicated was unsubstantiated based on interviews with employees and review of the residents Medication Administration Record for the month of November 2020. The resident was unable to be interviewed due to Alzheimer's diagnoses. The investigation into the allegations included: Observation of the resident of concern walking around the facility and participating in group activities. Interviews with one Med Tech, three Caregivers, one Executive Director and one Business Office Manager. Document review of Medication Technician duties and Medication Administration. Five resident files reviewed and four employee			

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	files reviewed. The findings and conclusions of any investigation by the Health Division 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. The following regulatory deficiencies were identified			
0755 SS= D	Unmanageable / Manageable Incontinence - NAC 449.2722 Residents having unmanageable condition of bowel or bladder incontinence; residents having manageable condition of bowel or bladder incontinence. (NRS 449.0302) 3. The caregivers employed by a residential facility with a resident who has a manageable condition of bowel or bladder incontinence shall ensure that: (a) If the resident can benefit from scheduled toileting, he or she is assisted or reminded to go to the bathroom at regular intervals; (b) The resident is checked during those periods when he or she is known to be incontinent, including during the night; (c) The resident is kept clean and dry; (d) Retraining programs are designed by a medical professional with training and experience in the care of persons with bowel or bladder dysfunction; (e) The retraining programs established for a resident are followed; and (f) Privacy is afforded to the resident when care is being provided. Inspector Comments: Based on interview and document review, the facility failed to ensure residents with unmanageable incontinence were changed frequently; an Incident report dated 09/19/20 reported residents wore double briefs (diapers). The Executive Director verbalized the employees were re-trained on incontinence care. Severity: 2 Scope: 1	0755	1. The findings was corrected by re-training the whole staff on incontinence care in September again. All of them in initial training was trained on personal care of all the residents. Disciplinary action was taken on staff member and she is no longer with this company. 2. The staff will document any changed on Docuwhiz.com when a residents has a change in care. Staff will be terminated on the spot if occurs again. 3. This will be monitored online daily 4. by the Wellness Care Supervisor, Executive Director and Administrator 5. This was completed in September after the issue was brought up to the Wellness Care Supervisor. Meeting and re-training was held on September 19th and Executive Director informed the surveyor at the time of survey. 6. See attached documents for Docuwhiz.com training 7. With documentation on personal care services on resident in change of condition will hinder this from happening and we can take the appropriate actions to ensure the care to the resident.	09/19/2020