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 _____	**04/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRECIOUS CARE GROUP	**7345 ACACIA WOODS CT, LAS VEGAS, NEVADA ,89113**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 04/20/23, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The census at the time of the survey was seven. The sample size was two. The facility received a grade of A. There was one complaint investigated. Verified: Complaint #NV00068239 was verified. (See Tag Y0556 and Y0853) The investigation of the Complaint included: Observation of the facility environment including number of staff in the facility, signs of no restraints being used, and the general well-being of the residents in the facility. Interviews with a caregiver, the owner, residents, and hospice employee. Record review of the resident of concern and three employee files. Document review included facility policy and procedures, incident report log, and an incident report from hospice nurse. 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JOSEPH ANORUO Title: Manager Date: 07/03/2023

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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0102 SS= E	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; Inspector Comments: The facility failed to ensure an annual Tuberculosis (TB) test was completed for 2 of 3 employees. (Employee #1 and #2) Findings include: Employee #1 (E1) E1was hired as the owner of the facility on 06/16/16. A review of E1's file documented the last TB test was completed on 01/10/22. Employee #2 (E2) E2 was hired as a Caregiver on 06/16/16. A review of E2's file documented the last TB test was completed on 01/10/22. On 04/20/23 at 1:00 PM, E1 acknowledged the annual TB tests for E1 and E2 were expired and should be completed on an annual basis. Severity: 2 Scope: 2	0102	Employee 1 while monitoring the TB screen thought that the expiration date of the medication as written on the sheet was the due date of the TB screen for the employees, however employee #2 had completed his annual quantiferon test on January 2023, and employee 1 & 3 completed their annual immediately after the inspection as was communicated with the inspector on April 2023. Employee will look closely to ensure that such oversight did not occur again and will monitor.	07/03/2023

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0104 SS= E	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 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: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview and record review the facility failed to ensure a background check was completed every five years through the Nevada Background Check System (NABS) for 2 of 3 employees. (Employee #1 and #2) Findings include: Employee #1 (E1) E1 was hired on 06/16/16 as the Owner/Caregiver. E1's file lacked documented evidence of a current NABS clearance letter. E1's NABS clearance letter expired on 06/05/22. Employee #2 (E2) E2 was hired on 06/16/16 as a Caregiver. E2's file lacked documented evidence of a current NABS clearance letter. E2's NABS clearance letter expired on 06/27/22. On 04/20/23 at 1:00 PM, E1 acknowledged the NABS clearance letters for E1 and E2 were expired and should be renewed every five years. Severity: 2 Scope: 2	0104	On Nevada Background Check System (NABS) for Employee #1 and #2), I did not know that it expires in 5 years and our administrator had medical issues and resigned emergently in February and we were looking for administrator at the time of the investigation However, the above concern was communicated to the inspector while on site and he advised me to update it and send him updated document which was done as advised. See attached communication with the inspector.Furthermore, Inspector was informed that employee #1 completed background check in NABS in February 2023 when he applied for RFA administrator license and was confirmed as being in good standing as attached. Employee #2 (E2) completed the background check as advised by the inspector and documents of completion was sent to him as requested as clearly shown on the e-mail communication and attached documents Employee #1 now knows that Background check expires every 5 years and will monitor compliance. The corrective action was corrected on 03/21/2023 and April 23, 2023 respectively.	07/03/2023
0556 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on record review and interview the facility failed to	0556	Contrary to to the report, Employee #1 informed the investigator that on 4/14/2023 at about 3.22pm he received a missed call from Hospice nurse (RN-P) and called her back around 3:28pm. During the call she alleged that her hospice CNA that came to take care of the patient on 4/13/2023 around 8:30AM informed her that she saw index patient tied to the wheelchair when she came to take care of the patient. I informed her that I had no record or complaint of that but I will contact the caregivers to find out more information about the report. When I contacted the caregivers, no one confirmed knowledge of	07/03/2023

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	ensure an allegation of abuse was reported to the Aging and Disability Services Division (ADSD) as prescribed in Nevada Revised Statute (NRS) 200.5093. Findings include: Resident #1 (R1) R1 was admitted to the facility on 07/17/21, with diagnoses including Alzheimer's disease and dementia with anxiety. On 04/20/23 at 11:30 AM, Employee #1 (E1) indicated R1 was tied to their wheelchair with a bathrobe on 02/13/23 by R1's visiting hospice nurse. E1 revealed they were notified by facility staff via text message about the incident. E1 indicated the facility notified R1's responsible party and met with them that night. There was no documented evidence the facility contacted ADSD regarding the incident. On 04/20/23 at 1:00 PM, E1 acknowledged the facility did not report the allegation of abuse to ADSD within twenty-four hours and should have. Severity: 2 Scope: 1 Complaint #NV00068239		such incident as the hospice caregiver did not inform any staff of the facility of such incidence or obtain permission from family to take pictures that was later adduced as alleged evidence. I later contacted the hospice RN-P that evening around 6:40pm to find out details of the report and she declined to disclose what she knew and informed me that her director will reach out to me and the family. The following day, the hospice director contacted me and the family. The matter was also reported to the visiting ombudsman and a meeting was convened between the hospice, the facility, the family and the ombudsman on 2/22/2023. During the meeting and on my request for the hospice team to explain what happened, the hospice director stated that their hospice CNA who came to to provide activities of daily living on 2/13/2023 witnessed the incident as stated above and took picture as alleged evidence showing a lady in a wheelchair dressed long pant, shirt and in a night robe. The picture was not clear where, when and the time the picture was taken and who was in the picture and who authorized the picture to be taken. The hospice suggested lab buddy which he bought at the spot online. The brother was worried that the hospice CNA violated her sister's privacy instructed the hospice team to immediately stop the caregiver from taking care of her sister and that was immediately done. I requested to know if any of our facility staff was informed or witnessed the incident and she answered, No! i further asked if any of my staff or family authorized her to take the picture. The also answered, no! The brother said that he would not mind and will approve any measure to prevent her sister from falling and hurting herself and requested a document to be signed to	

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			permit her sister to be restrained instead of falling. We advised him that per state policy, we are not allowed to restrain residents and that although, physical restraint in rare circumstances when used to prevent injury can be used, we do not not recommend or use it in our facility. The ombudsman had a meeting with me and the family. During her investigation, I explained the above information to her and that the patient is alzheimer and dementia patient, a wanderer with unstable gait and fall risk, on lorazepam as needed for aggression and monitored with bed and chair alarm. She also contacted the family and interviewed the brother. During the ombudsman follow up, she informed me that the brother of the patient did not believe that her sister is being abused in any way. Employee #1 believed that the issue was resolved and appropriately reported to Aging and Disability Services Division (ADSD) through the ombudsman who came and interviewed employee #1. Employee #1 will ensure that all incident reports are reported to appropriate quarters for necessary investigation to be carried out and document report in desirable incident reporting system. The corrective action was taken on 4/20/2023.	
0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record	0853	As explained in TAG 0556, the report was properly documented in print but not in an incident report. Employee #1 did not have the details of the alleged complaint until the day he met with hospice team and the patient family on 2/22/2023. The encounter was well documented but not in an incident form because of the nature of the complaint.	07/03/2023

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	must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on interview and record review, the facility failed to ensure an incident report was completed for an incident where a resident was tied to a wheelchair with a bathrobe. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted to the facility on 07/17/21 with diagnoses including Alzheimer's disease and dementia with anxiety. On 04/20/23 at 11:30 AM, Employee #1 (E1) indicated R1 was tied to their wheelchair by R1's visiting hospice nurse. E1 revealed they were notified by facility staff via text message and E1 arrived at the facility shortly thereafter. E1 indicated they notified R1's responsible party and met with them that night. E1 verbalized no incident report was completed regarding the incident. E1 provided an Incident Report Log with no completed incident reports. The facility's incident report log revealed a binder with several blank incident report forms inside. A review of an undated facility policy titled "Incident Reports" documented the Unusual Incident Form was used to document and report any incident which was a threat to a resident's health, safety, welfare, or rights. On 04/20/23 at 1:00 PM, Employee #1 (E1) acknowledged an incident report following an incident of abuse where the Resident of Concern was tied to a wheelchair with a bath robe which occurred on 02/13/23 was not completed and should have been completed in compliance of facility policy. Severity: 2 Scope: 1 Complaint		Employee #1 notes that the facility has incident reporting form and uses it when we observe an incident.	

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