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 _____	**08/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	**6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108**

(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 the State Licensure Complaint Investigation survey initiated at your facility on 07/14/22 and concluded on 08/23/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for 150 Residential Facility for Group beds for elderly or disabled persons and/or persons with Alzheimer's Disease, with an endorsement for Assisted Living Services, 50 Category I and 100 Category II residents. The census at the beginning of the survey was 72. Three resident records were reviewed. The facility received a grade of A. One complaint was investigated: Complaint #NV00066648 with five allegations was substantiated: The allegation there was no current Administrator licensed in the State of Nevada for the facility was substantiated. See TAG Y0040. The following allegations were unsubstantiated: Allegation #1: The air conditioner was not working on the second floor hallways and the temperature was unbearable was unsubstantiated based on observations on 07/14/22 and 08/23/22 of second hallway temperatures ranging from 62 degrees Fahrenheit (F) to 78 degrees F. Interviews conducted with the Executive Director and the Maintenance Director revealed an air conditioner unit in one hallway was repaired on 07/13/22, and the facility provided a portable air conditioning unit in that area to maintain the temperature at 78 degrees F or less. Interviews with four residents and four staff members who reported the facility was always maintained in a cool, comfortable temperature. Document review included vendor invoices of air conditioning repair, rental of a portable air conditioning unit, and maintenance temperature logs. Allegation #2: A resident was admitted on 07/04/22 without COVID testing and tuberculin (TB) testing was unsubstantiated based on	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: BRIAN MURPHY Title: Administrator Date: 01/25/2023

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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	review of three sampled records, including the resident of concern, and review of the documented COVID-19 negative test results and initial 2-step TB test with negative results. Allegation #3: Residents are missing medications and not receiving medications in a timely manner was unsubstantiated based on review of three resident records, including medication administration records, physician's orders, and medication reconciliation, which revealed residents were receiving medications per physician's orders and medications were not missing. Interviews with a Medication Technician (Med Tech) and the Executive Director revealed medications were administered to residents in a timely manner per physician's orders. Allegation #4: Physical examinations were not being completed was unsubstantiated based on review of three resident records, including current history and physical examinations. The investigation into these allegations included: Observation and walk through of the facility on 07/14/22 at 10:30 AM and on 08/23/22 at 1:45 PM, temperature measurement of the second floor hallways, interviews with the Executive Director, the front Receptionist, four residents, the Director of Maintenance, and a Medication Technician (Med Tech), record review of three residents, Medication Administration policy review, and document review of air conditioning invoices and temperature logs. 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 regulatory deficiencies were identified:			

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0040 SS= F	Supervision of AGC - NRS 449.186 Supervision of residential facility for groups. A residential facility for groups must not be operated except under the supervision of an administrator of a residential facility for groups or a health services executive licensed pursuant to the provisions of chapter 654 of NRS. Inspector Comments: Based on observation and interview, the facility failed to maintain a licensed Administrator. Findings include: On 07/14/22 and on 08/23/22, there was no licensed Administrator available at the facility. On 08/23/22 at 2:00 PM, the Executive Director acknowledged the previous Administrator surrendered the original Administrator's license to the Board of Examiners of Long-Term Care Administrators (BELTCA) Office on 06/30/22. On 08/23/22 at 4:00 PM, a BELTCA Representative verified the previous Administrator surrendered the Administrator's license on 06/30/22. The Representative indicated there was no current licensed Administrator for the facility as of 06/30/22. Review of the Bureau's online licensing system revealed no evidence the facility had submitted an application for a change of Administrator. Severity: 2 Scope: 3 Complaint #NV00066648	0040	1. How will you correct the specific finding stated in the Statement of Deficiency. A: A administrator was hired on 9/23/2022. 2. What measures or systemic change will be put into place to ensure that the deficient practice does not recur? A: Our Senior Regional Vice President has been made aware of the state requirements and will monitor the license status. 3. How will the corrective action be monitored to ensure the deficient practice will not recur. A: Our corporate office will monitor the license status of the administrator. 4. The title of the person responsible for ensuring the plan of correction is implemented. A: the senior Regional Vice President will be responsible for the implementation of this POC.	09/23/2022