STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	04/05/2023

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and infection control survey conducted in your facility on 04/20/22, in accordance with Nevada Administrative Code (NAC) 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 time of the survey was 53. Sixteen resident files and ten employee files were reviewed. The facility received a grade of B. 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 deficiencies were identified:	0000		
0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure water temperatures were within the acceptable range of 100 degrees Fahrenheit (F) and 110 degrees Fahrenheit (F). Findings include: On 04/05/23 in the morning, the water in multiple residents rooms was hot to the touch. On 04/05/23 between 09:30 AM and 10:30 AM, the following sink water temperatures were measured by the Maintenance Director: Room #231: 124.1 degrees F Room #244: 129.4 degrees F Room #242 124.3 degrees F Room #253: 124.3 degrees F Room #269: 126.2	0174	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies- The plumbing company came in and adjusted the water temperature mixing valve to regulate the community water temp. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur- water temperature checks have been scheduled to weekly from monthly.	04/16/2023

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	degrees F Room #150: 124.3 degrees F Room #160: 125.1 degrees F Room #119: 128.4 degrees F On 04/05/23 at 10:30 AM, the Maintenance Director acknowledged the water temperatures were out of an acceptable range of 100 degrees F and 110 degrees F and were too hot for residents to touch and acknowledged water temperature logs were not maintained. On 04/05/23 in the afternoon, the Administrator acknowledged the facility water temperatures were not in acceptable range of 100 degrees F and 110 degrees F. Severity: 2 Scope: 3		3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur- Our Plant Operation Director will oversee and document water temperature in our TELS system and report to the Executive Director if temperatures are out of range. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented- The plant Operations Director will be responsible for monitoring, delegating, and reporting to the Executive Director	
0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 04/05/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the reach-in portion of the deli preparation refrigerator, chicken salad was prepared on 03/27/23 and was held longer than seven days. 2. Major Violations: a. Two of four hand washing sinks were not supplied with	0255	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies- 1. The outdated chicken salad was immediately removed from the delipreparation refrigerator. 2A.new soapdispensers were installed near all four sinks as well as the paper toweldispensers were	04/14/2023

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	paper towels and one hand washing sink was not supplied with soap. b. The exhaust ventilation system on both sides of the high temperature dish machine were not observed to be operating and a heavy amount of steam was emitting out of the machine. 3. Equipment and Maintenance Violations: a. The base cover on the back of the double-door reach-in refrigerator in the servery was not installed on the unit. Severity: 2 Scope: 2		filled. 2B. Afterinspection the drive belt was slipping and not engaging the fan. Drive belt was replaced and exhaust fan isrepaired. 3. Base cover was reinstalled. 2) Whatmeasures or systematic change(s) will be put into place to ensure the deficient practice does not recur- Routine inspections will be conducted on a monthly basis and documented inour TELs system. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur- OurPlant Operation Director will overseeand document all inspections. 4) The title of the person (position)	

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			responsible for ensuring the plan of correction is implemented- The plantOperations Director will be responsible for monitoring,delegating, and reporting to the Executive Director	
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must	0878	1 How you will correct the specific finding(s) stated in the Statement of Deficiencies- R-14 Asper crème was labeled. R-14 other mentioned medication was DCd by the doctor. R-15 meds were ordered and received on 4/5/2023. R-16 Meds were ordered and received on 4/6/2023. 2) What measures or systematic change(s) will be put into place	04/13/2023

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	be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation and interview, the facility failed to ensure 3 of 16 sampled residents medications were available as prescribed (Resident #14, #15, and #16); a resident's medication was labeled (Resident #14), and a resident's medication had a physician's order (Resident #14). Findings include: Resident #14 (R14) R14 was admitted on 03/05/20, with diagnoses including hemiplegia. A physician's order dated, 11/08/21 documented cool and hot liquid 16 percent (%). Apply to the upper back and shoulder topically every 12 hours as needed for pain. The medication on-site was Aspercreme Lidocaine 4%. The 4% medication was not labeled with the resident's name and physician. The 16% cream was not on-site. The Resident Services Coordinator verified there was no label with R14's name and physician and no physician's order for the Aspercreme Lidocaine 4% cream and the 16% cream was not on-site and available to R14. A physician's order dated, 11/10/21 documented Fiber capsule. Take one capsule by mouth as needed for bowel regimen. The medication was not on-site. The Resident Services Coordinator was unable to locate the medication on the cart and verified the medication was not onsite and available to R14. Resident #15 (R15) R15 was admitted on 07/02/20, with diagnoses including dementia. A physician's order dated, 11/08/21 documented Preservation Vitamin. Take two capsules by mouth every day. The medication was not on-site. The Resident Services Coordinator was unable to locate the medication on the cart and verified the medication was not onsite and available to R15. Resident #16 (R16) R16 was admitted on 11/09/22, with		to ensure the deficient practice does not recur- An in-service was given to the current HCC's and monthly in-services X6 will be given on proper medication management. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur- RCCs will conduct weekly medication Cart Audits and they will communicate with the HCCs on necessary changes. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented- The Health Services Director will be responsible for monitoring, delegating, and reporting to the Executive Director	

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	diagnoses including dementia, hypertension and multiple sclerosis. A physician's order dated 09/30/20 documented Benadryl Extra Strength 2-0.1, apply sparingly to affected area(s) three times a day. The medication was not on-site. On 04/05/23 in the morning, a Medication Technician was unable to locate the medication on the cart and confirmed the medication was not on site and available to R16. Severity: 2 Scope: 1			
0930 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation and interview, the facility failed to ensure protected health information was properly secured. A staff computer in a common area hallway, was unlocked and open to a resident's medical information and no staff were present in the area for over five minutes. The Business Office Manager confirmed the computer screen containing a residents personal information was visible, there were no staff present in the area, and the screen should have been locked. Severity: 2 Scope: 1	0930	1 How you will correct the specific finding(s) stated in the Statement of Deficiencies- The computer was removed from the common area. Staff member was given training on HIPAA. Staff was also in-serviced on HIPAA. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur- Monthly in-services X6 will be given to staff a tour all staff meeting. 3) How the corrective	04/13/2023

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			action(s) will be monitored to ensure the deficient practice will not recur- All staff members will be responsible for monitoring any HIPAA violations. Director team will be responsible for the QAPI process. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented- The Executive Director will be responsible for monitoring, delegating, and reporting.	
1305 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post	1305	1 How you will correct the specific finding(s) stated in the Statement of Deficiencies- the required sign was created and hung.	04/04/2023

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	prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. Inspector Comments: Based on observation and interview, the facility failed to ensure a non-discrimination statement was posted at the entrance to the facility. There was no non-discrimination statement posted near the front of the facility. On 04/05/23 in the morning, the Administrator confirmed there was no non-discrimination statement posted at the entrance to the facility. Severity: 1 Scope: 3		2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur- no systemic changes are needed. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur- The BOM will monitor all licenses, insurances, and compliance material. She will then report to the Director team for the QAPI process. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented- The Executive Director will be responsible for monitoring, delegating, and reporting.	

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