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 _____	**02/28/2024**

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 and complaint State Licensure survey completed at your facility on 02/28/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 150 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, 50 Category 1 and 100 Category II residents. The census at the time of the survey was 96. Twenty resident files and ten employee files were reviewed. The facility received a grade of A. The sample size was 20. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00070352 was unsubstantiated. The investigation of the Complaint included: Observation of staff/resident interactions. Interviews were conducted with residents, the Administrator, and a Medication Technician. Clinical record Review of 10 records, which included the resident of concern. Document Review included facility policy and procedures and grievance 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:	0000		
0820 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless:	0820	1. **How will you correct the specific findings stated in the SOD?** HSD/Designee will ensure that any resident with a wound will have a wound exemption. 2. **What Measures or systematic changes will be put in place to ensure the deficient practice does not recur?**	05/28/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: BRIAN MURPHY Title: Administrator Date: 04/10/2024

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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	(a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or (c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. Inspector Comments: Based on interview and record review, the facility retained a resident with a wound which was not in the process of healing for one resident (Resident #17). The facility did not have a medical exemption on file to retain a resident with a wound. Findings include: Resident #17 (R17) R17 was admitted to the facility on 11/09/22 with diagnoses including history of cerebral vascular accident, morbid obesity, and multiple sclerosis. The Physician's Assessment dated 01/31/24 documented R17 had the following wounds: 1) Diffuse venous ulcers on lower left extremity leg and foot, second toe left appeared infected. Wound care three times a week for treatment of weeping ulcers and edema with ulna boots. Significant skin slough that needed to be debrided. 2) Bilateral buttock pressure ulcers. The physician orders dated 02/21/24 documented wound care to bilateral lower extremities and coccyx. There was no documented evidence the wounds were in a healing condition. On 02/28/24 at 2:00 PM, the Medication Technician indicated R17's coccyx wound was often cracked and bleeding when they changed the resident's brief. On 02/28/24 at 2:30 PM, the Administrator acknowledged R17 had an open wound, and the facility did not submit for a medical exemption to the Bureau to retain a resident with an open wound. Severity: 2 Scope: 1		HSD/designee will audit all shower sheets to make sure anyone with an open wound will have a wound care plan of care as well as an exemption. 3. **How will the corrective action be monitored to ensure the deficient practice will not recur?** Audit tool will be utilized by HSD or designee to monitor compliance. 4. **The title of the person responsible for ensuring the plan of correction is Implemented** HSD	

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 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) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on interview and record review, the facility failed to ensure 1 of 20 sampled residents (Resident #14) received an annual physical examination. Findings include: Resident #14 (R14) R14 was admitted on 08/28/2021 with a diagnosis including hypertension. R14's medical record revealed a History and Physical dated 12/05/2022. R14's medical record lacked documented evidence an annual physical examination was completed. On 02/28/2024 at 2:01PM, the Director of Health Services acknowledged an annual physical examination was not completed and on file for R14. Scope: 2 Severity: 1	0859	2. 1. **How will you correct the specific findings stated in the SOD?** a. HSD/Designee ensured that each service provider will complete an annual History and Physical for each resident. 2. **What Measures or systematic changes will be put in place to ensure the deficient practice does not recur?** a. HSD or designee will audit charts to stay compliant. 3. **How will the corrective action be monitored to ensure the deficient practice will not recur?** a. Audits will be conducted by the HSD or designee to monitor compliance. 4. **The title of the person responsible for ensuring the plan of correction is Implemented.** a. HSD	05/28/2024
1700 SS= C	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of	1700	1. **How will you correct the specific findings stated in the SOD?** a. HSD/Designeeensured that each service provider will complete a standard placement form uponadmission and annually thereafter.	05/28/2024

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	health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on interview and record review, the facility failed to		2. **What Measures or systematic changes will be put in place toensure the deficient practice does not recur?** a. HSD /designee will audit allcharts every 3 to 4 months to ensure completion. 3. **How will the corrective action be monitored to ensure thedeficient practice will not recur?** a. Audit will be completed by theHSD or designee to monitor compliance. 4. **The title of the person responsible for ensuring the plan ofcorrection is Implemented.** a. HSD	

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	ensure an annual placement assessment and/or initial placement assessment was obtained for 13 of 20 residents (Resident #1, #3, #4, #5, #6, #8, #10, #11, #12, #14, #17, #18, and #19). Findings include: Resident #1 (R1) R1 was admitted on 08/05/23 with diagnoses including stroke with residual right-sided deficit and weakness, diabetes, and high blood pressure. R1's record lacked a completed placement assessment. Resident #3 (R3) R3 was admitted on 11/30/17 with diagnosis including chronic obstructive pulmonary disorder and unspecified dementia. A placement assessment for R3 was last completed 09/20/21. Resident #4 (R4) R4 was admitted on 05/25/19 with diagnosis including anxiety disorder and chronic kidney disease. A placement assessment for R4 was last completed 09/24/20. Resident #5 (R5) R5 was admitted on 07/17/23 with diagnoses including unspecified encephalopathy, acute kidney failure, high blood pressure and generalized muscle weakness. R5's record lacked a completed placement assessment. Resident #6 (R6) R6 was admitted on 07/30/21 with diagnosis including hypertension and esophageal reflux disorder. A placement assessment for R6 was last completed 07/24/21. Resident #8 (R8) R8 was admitted on 09/27/23 with diagnoses including high blood pressure, unspecified atrial fibrillation, and hyperlipidemia. R8's record lacked a completed placement assessment. Resident #10 (R10) R10 was admitted on 01/30/15 with diagnosis including hypertension and hyperlipidemia. A placement assessment for R10 was last completed 12/10/19. Resident #11 (R11) R11 was admitted to the facility on 11/30/23, with diagnoses including hypertension and depression. R11's file lacked a completed placement assessment. Resident #12 (R12) R12 was admitted to the facility on 12/31/23, with diagnoses including hypertension and hyperlipidemia.			

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	R12's file lacked a completed placement assessment. Resident 14 (R14) R14 was admitted on 08/28/2021 with diagnoses of hypertension. R14's file lacked a completed placement assessment. Resident #18 (R18) R18 was admitted on 08/13/21 with amyloidosis and hyperlipidemia. A placement assessment for R18 was last completed 08/12/21. Resident #19 (R19) R19 was admitted to the facility on 02/19/24, with diagnoses including hypertension and osteoporosis. R19's file lacked a completed placement assessment. On 02/28/24 in the afternoon, the Administrator acknowledged an annual placement assessment and/or initial placement assessment was not obtained for Resident #1, #3, #4, #5, #6, #8, #10, #11, #12, #14, #17, #18, and #19. Severity: 1 Scope: 3			