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 _____	**05/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA COURT ASSISTED LIVING AND MEMORY CARE	**4025 SOUTH PEARL STREET, LAS VEGAS, NEVADA ,89121**

(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 conducted at your facility on 05/20/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for 40 Residential Facility for Group beds for elderly / disabled persons, and/or persons with mental illnesses, and/or persons with chronic illnesses, and/or persons with Alzheimer's disease, and Assisted Living Services. The census at the time of the survey was 24. Two resident records were reviewed. The facility received a grade of A. One complaint was investigated: Complaint #NV00066359 with three allegations was substantiated: Allegation #1: The air conditioning was not working properly in several areas in the Memory Care Unit was substantiated with no regulatory deficiencies based on acceptable temperature measurements throughout the facility at the time of the survey. The Administrator and the Maintenance Director confirmed the air conditioner was previously in disrepair but was fixed, and provided invoices dated 05/06/22 from the air conditioner repair vendor. Allegation #2: A window leading to the courtyard is missing a screen was substantiated. See TAG Y0179. Allegation #3: An area blocked off for COVID residents had doors which were blocked by a table and chairs, and the residents in that unit were pounding on the door, was substantiated. See TAG Y515. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ELIZABETH TUCHMAN | Title: Operations Manager | Date: 07/01/2022

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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0179 SS= F	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview the facility failed to ensure all windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility were screened to prevent the entry of insects. Findings include: On 05/20/22 in the afternoon, a tour of the of the facility and courtyard revealed two windows without screens, and two windows with bent screens that failed to prevent the entry of insects. In addition, one set of doors leading to the courtyard were propped open without screens. On 05/20/22 in the afternoon, the Maintenance Director and the Wellness Director acknowledged the missing and broken screens. The Maintenance Director indicated that replacement screens were on order and would be replaced upon delivery. Severity: 2 Scope: 3 Complaint #NV00066359	0179	In accordance with NAC 449.209, 4 window screens were fixed/replaced. The window screens were drilled to the frames, so the screens do not bend or fall off. The door leading out to the courtyard will remain closed to prevent the entry of insects. A maintenance weekly log will be performed by our maintenance team to ensure that all window screens are in proper condition.	06/30/2022
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on observation, interview, and record review, the facility failed to provide protective supervision for two residents (Resident #1 and #2). Findings include: Resident #1 (R1) R1 was admitted to the facility on 04/01/22 with diagnoses including late onset Alzheimer's disease and diabetes mellitus. Resident #2 (R2) R2 was admitted to the facility on 09/11/20 with diagnoses including	0515	1. In accordance with NAC 449.259, the contained area has been dismantled and the double doors remain open. A phone conversation with Lisette Mendoza on 05/18/2022 at approximately 1:30pm, it was advised that our two COVID-19 positive residents be isolated in an area away from other residents. Lisette informed that a designated staff member for these residents is suggested, but due to staffing shortages having a designated staff member located inside of the contained area can be difficult and residents must be checked on frequently for safety. Emergency call buttons are located behind double	06/30/2022

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	dementia, degenerative joint disease, and fall risk. On 05/20/22 at 12:25 PM, two residents (Resident #1 and #2) were in a contained area (Room #19, Room #20, and a hallway) separated from the rest of the facility by double doors. There were no staff members supervising residents in the contained area. The doors were closed and there were several chairs blocking access to the doors on the inside. There were chairs against the other side of the door, and there was a resident sitting on one of the chairs. The resident stated, "They told me to sit here. I am sitting here because two residents keep trying to escape.". The resident indicated the residents inside yelled "a lot". A Hospice Nurse indicated there were multiple times the doors were kept closed with tables and chairs blocking the doors, and residents were yelling and shouting they wanted out. Another Hospice Nurse verbalized there were multiple times there were no staff inside the area with the residents, and the facility blocked the doors and let the residents inside pound on the door and scream. The Executive Director and the Administrator acknowledged the contained area did not have at least one staff member continuously supervising the two residents, and there was no way to visually monitor the residents. The Wellness Director and a Caregiver indicated the residents often yelled and pounded on the doors. Severity: 2 Scope: 1 Complaint #NV00066359		doors if residents required emergency help. Emergency call buttons are in bedrooms and bathrooms of contained area. On 5/20/2022, Ken Kitto advised that we purchase auditory alarms to place on the double doors. Ken noted this would eliminate the need to have an employee inside the double doors continuously and would not impact our staffing ratio. Auditory alarms were purchased on 05/20/2022 at 6:00pm and placed on double doors on 05/20/2022 at6:35pm. An In-Service was conducted on 06.30.2022 with Wellness Staff to review NAC 449.259 and to retrain on resident supervision and safety.	