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 _____	**02/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated in your facility on 02/08/24 and completed on 03/11/24, in accordance with Nevada Administrative Code (NAC), Chapter 449. The census at the time of the survey was seven. The sample size was five. The facility received a grade of B. There was one complaint investigated. Verified: 1. Complaint #NV00070410 was verified. (See Tags Y220, Y276, Y592) The investigation of the Complaint included: Observation of grooming and physical appearance of residents, interactions between Caregivers and residents, resident medications, the contents of kitchen cupboards and refrigerator, the laundry room, and a tour of the facility. Interviews were conducted with residents, the Caregiver, and the Owner. Clinical Record Review of five resident records, physician orders and review of four employee files. 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		
0220 SS= F	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where	0220	Since multiple attempts to repair the washing machine in the facility was made but only provided temporary resolution. Manager of facility decided to buy new washing machine for the group home. Washing machine was delivered on 03/21/2024 In order to make sure that the residents clothing does not get mixed up - facility will observe and implement Laundry Schedule (see Attached form) to limit the amount that needs to be washed in a given day and to make sure caregivers can check and organize resident clothing. - Process was	03/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: DEORELLA A BAUTISTA | Title: Manager | 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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	food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on observation and interview, the facility failed to ensure the washing machine was kept in working order. Findings include: On 02/08/24 in the afternoon, the washing machine was observed not to be working. The Caregiver explained the residents' clothing was brought to a laundromat to be washed, and brought back to the facility to be dried. The Caregiver confirmed the washing machine drum and the lid lock were broken, and explained the person who had delivered the new drum did not know how to install it. In an email from the facility sent on 02/12/24, the Owner provided a receipt from the a local service center for the washing machine repair. The date of the receipt was not readable, therefore the timeframe in which the washer was broken could not be determined. In an email sent from the facility on 03/11/24, the Owner indicated the washer was never fixed correctly. Severity: 2 Scope: 3 Complaint #70410		started March 22, 2024 Manager has also reached out to family of the resident to provide additional clothing that they can use.	
0276 SS= F	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are	0276	To prevent reoccurrence of the incident - Group home will re-educate caregiver with Basic Kitchen Inventory System to better monitor food supply. (1) Weekly inventory, clean up will be conducted in the group home. (2) Utilize Labeling System - reinforced instruction to caregiver to use clear labels to help in quickly identifying items. (3) Implement a FIFO System" First in, First Out" to avoid spoilage and ensure fresh stock is always in hand. Training was provided March 25, 2024	03/18/2024

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	not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation and interview, the facility failed to ensure food was not expired and was suitable for residents. Findings include: On 02/08/24 in the morning, the following was observed: - A bag of walnuts which expired on 08/16/21. - A container of Parmesan cheese which expired on 11/03/23 in the refrigerator. - An open jar of pesto which expired on 10/04/22. - Another jar of pesto which expired on 10/16/22. - A jar of pickled beets which expired in 2020. - A container of cottage cheese which expired on 11/27/23 - Three nutritional shakes which expired on 12/21/23. - A jar of barbeque sauce which expired in July of 2023. - An old orange on the counter On 02/08/24 in the afternoon, the Caregiver acknowledged the expired food and indicated it was not suitable for residents. On 02/08/24 in the morning, a resident verbalized they received no snacks, the food could have a better taste and quality, and the facility could serve more hot meals. On 02/08/24 in the morning, a resident reported to being a vegetarian and explained they received "junk food," such as muffins and crackers, to eat. The resident indicated no vegetables or fruits to their liking was provided. On 02/08/24 in the morning, a resident reported the food was so spicy and could not eat it. Breakfast was often cold, with runny eggs on top of pancakes. Lunch was usually one thin slice of ham and one slice of cheese on toast. Their family member went to the store to get some food they liked, but many times the Caregivers refused to cook it. The resident had a lot of non perishable food stored in the resident room. On 02/08/24 in the afternoon, the Owner acknowledged the facility needed to have more fresh fruit on hand. Severity: 2 Scope: 3 Complaint #70410		Manager will check residents opinion on meals and request/ preferences and will attempt to incorporate them into the menu. At the end of each month prior to posting New months Menu - Completed March 30, 2024 On going monitoring will be performed by manager and administrator to make sure systematic change will create a difference in the kitchen process.	
0592 SS= E	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents;	0592	Resident on Shared room that has both complaint regarding tv and clothing was	03/18/2024

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	procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity; Inspector Comments: Based on observation and interview, the facility failed to ensure residents were treated with dignity and respect. Findings include: On 02/08/24 at 11:50 AM, a resident walked into the kitchen wearing incontinence briefs and no pants. Employee #4 (E4) impatiently asked the resident what they were doing, coming out from their room without wearing pants. The resident did not flinch at the comment. Later in the morning, the resident had indicated the way the staff spoke to them was below average. The resident used a scale of one to ten (ten being the best) and reported a 4 out of 10 for the way they were spoken to. The resident shared they felt a safety level of 5 on a scale from one to ten. On 02/08/24 in the morning, another resident who had clothes spread out all over their bed, verbalized sometimes staff could be a bit rude but other times they went to bat for you and other times they were just rude. The resident explained when the facility washed their clothes, the clothes were not that clean and they did not want the facility to wash their clothing. The resident does not trust the facility to get the clothes clean or to return them. The resident would lay their clothing on the bed to dry, to wear again. On 02/08/24 in the morning, another resident reported the staff can be very nice and very respectful, "except when they're mad at me," which the resident explained was very rare. The resident reported to never being hit by staff, but Employee #5 (E5) was a little rough sometimes. On 02/08/24 in the morning, the television (TV) in a resident room shared by two residents was not working. The residents reported the TV was broken all the time and was their favorite form of		addressed 02/09/2024. Explained the issue with laundry and the action that the group home provided (scheduled laundry and labeling of clothing). Posted Sign in Laundry room and stress out importance of compliance to caregiver on duty. Resident 1 that walks in diaper was reminded about the group home facility of dress code but because of advancing Alzheimer's condition- manager received the same response as what the inspector received. Manager coach caregiver to provide additional supervision to make sure resident get assisted in wearing pants at all times. Resident 2 on shared room was known to wanting to take PRN medication more often that scheduled - case was discussed with hospice provider and medication was reviewed. Resident conditioned decline and was sent to hospital March 17, 2024. Room partition was placed in the shared room for privacy. Caregivers Conduct and Treatment to Resident was address - provided caregivers coaching and verbal warning. The incident was fully investigated with the involved caregiver and caregiver was re-educated in the Resident Centered Care approach in providing care - to make sure that their actions revolves around what is best for the resident. In an effort to identify any other resident with a concern regarding their treatment . The facility will at least quarterly Resident Satisfaction Survey to improve service provided to the resident. Process was completed April 1, 2024 Additional Action Plan Group Home manager will encourage	

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	entertainment. The TV provided escapism and they would get disgruntled when the TV was not working. On 02/08/24 in the morning, A resident indicated there were times when the Caregivers waited a while to change them and they felt it was sometimes too long. The resident reported they did not know where their clothes were, and indicated the facility lost track of their clothes, and did nothing about finding them. The resident explained they didn't always have the same clothes. The resident reported one time, E5 hit them hard on the buttocks when E5 was changing them. The resident described E5's behavior during the incident as "just mean." When asked how the Caregivers treat them, another resident replied, "Not well." The resident indicated the facility did not administer their pills correctly. On one occasion the resident argued with the Caregiver back and forth regarding the number of pills the Caregiver was supposed to administer and actually administered. The Caregiver left the room, came back and threw the pills into the cup. The resident verbalized the Caregivers didn't ask about the fan or the light, and they turned on the light while they were sleeping. The resident explained yesterday, the Caregiver brought them someone else's shirt. They informed the Caregiver it was not their shirt. The Caregiver checked the tag in the shirt, and it belonged to a resident who had left the facility. On 02/08/24 in the morning, the resident reported staff did not come in very often to change their commode, sometimes two or three days went by between changes. The resident shared that they felt "semi-" safe at the facility. The resident postulated staff could stop feeding them or quit giving them medications, which they reported to have happened. The resident verbalized one time a Caregiver put their pain pill in pudding, and then did not serve them dinner, but said they had received the pudding they had asked for. On 02/08/24 in the afternoon, the Owner acknowledged residents were not		resident and family to voice out concern to make sure incident can be appropriately investigated and corrective actions can be immediately provided , as warranted. As means to ensure on going compliance with the prohibition of mistreatment, neglect and abuse- in service training for elderly abuse will be provided. Completed 02/13/2024	

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	treated with respect in regard to personal clothing, food preferences, lack of television, and tone of voice. At 4:05 PM, the Owner verbalized the residents actually don't have their own clothes, and acknowledged the facility needed to change the process with the clothing, and that the TV should be fixed. Severity: 2 Scope: 3 Complaint #70410			
0878 SS= E	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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 , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. 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, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse 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 (3) Note the change in the record maintained pursuant to	0878	Manager and Administrator conducted Medication Review to the resident affected by the incident and to make sure medication supply was ordered and in the proper bin. Manager met with Resident 5 Nurse - February 12, 2024 to make sure they provide clear instruction on all change order, clarify drug dosage, frequency and other pertinent details to eliminate confusion. Also to make sure that the ordered medication for resident will be delivered promptly. - April 5, 2024 Resident was discharged and brought home by family. Resident 4 - Medication review and Concierge Healthcare Hospice provider conducted medication review and dc on medication. Updated List was received 02/13/2024 Manager required caregivers to watched video on Safe Handling and Administration of Medication. Caregiver's recently renewed Annual Medication Administration Certification and one is scheduled to attend Annual Certification as well. It will reinforce caregiver knowledge and importance of medication administration. ACTIVITY COMPLETED 02/13/2024 Administrator will continue to conduct medication review to make sure changes reflect correctly in the MAR for compliance.	02/12/2024

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	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, physician assistant or advanced practice registered nurse must 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, physician assistant or advanced practice registered nurse, a 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 interview and record review, the facility failed to ensure medications were on site and failed to ensure the Medication Administration Records (MARS) were accurate for 2 of 7 residents (Residents #4 and #5). Findings include: Resident #4 (R4) R4 was admitted on 08/28/23 with a diagnosis of hypertension. R4's February 2024 Medication Administration Record (MAR) documented Duloxetine HCl 60 milligram (mg) capsule, take one capsule by mouth once a day. R4's medication list documented a physician order dated 06/03/23 for Duloxetine 20 mg delayed-release capsule DR daily. R4's medication bin did not contain Duloxetine HCl. On 02/08/24 in the afternoon, the Caregiver acknowledged Duloxetine was not available in R4's medication bin. Resident #5 (R5) R5 was admitted on 01/22/24 with a diagnosis of lung cancer with metastasis to brain. A physician order dated 02/07/24 documented Budesonide 0.5 mg/2 ml use one vial via nebulizer twice daily. On 02/08/24 in the morning, the Caregiver explained Hospice provided Budesonide 0.5 mg/2 milliliters (ml). On 02/08/24 in the afternoon, the inhaler was not on site to use for			

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	administration of the Budesonide. R5's February 2024 MAR documented Trazadone tablet 150 mg, give two tablets by mouth at bedtime. A physician order dated 02/02/24 documented Trazadone 100 mg take four tablets by mouth every evening. On 02/08/24 in the afternoon, the Caregiver acknowledged R5's February MAR was incorrect and should have documented four tablets instead of two tablets Trazadone and verified the inhaler was not on site. Severity: 2 Scope: 2			