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 _____	**07/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA PARADISE CARE, LLC	**1809 WESTWIND ROAD, LAS VEGAS, NEVADA ,89146**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 07/07/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for persons with Alzheimer's disease, Category II residents. The facility received a grade of A. The census at the time of the survey was seven. The sample size was seven. One complaint was investigated. Complaint #NV00066498 with 16 allegations was substantiated. The allegation the facility did not offer activities for residents was substantiated. (See Tag 527). The following allegations could not be substantiated. Allegation #1. The facility removed a resident's call bell and the only way a resident could get assistance was by banging on the wall or yelling was unsubstantiated based on observation of residents being attended to regularly by staff when pressing call bells and the absence of residents yelling. Interviews with the Owner, a Caregiver and three residents indicated their needs were met and staff checked on them regularly. Allegation #2. Staff did not remove a resident from bed which led to resident attempting to get out of bed and falling was unsubstantiated based on observation of multiple residents being assisted out of bed, staff attending to residents and interviews with the Owner, a Caregiver and three residents who indicated staff helped them out of bed as needed. Review of incident reports did not document any resident falls due to staff not assisting residents. Allegation #3. Medications were used to sedate residents was unsubstantiated based on observation of residents being awake and alert. Interviews with the Owner, a Caregiver, a Hospice Nurse and three residents indicated medications used for sleep were only prescribed before bed. Review of	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROSALLEN AZUCENA | Title: RFA | Date: 07/26/2022

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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	Medication Administration Records (MAR's) and physician's orders for seven residents lacked documented evidence medications were being used or prescribed for sedating residents. Allegation #4. A resident's requests for food were not honored, residents were not allowed to have packaged food from family, and Ensure given to residents was watered down, was unsubstantiated based on observation of residents eating food items per their request in their rooms. Ensure was observed being opened and handed directly to residents and was not watered down. Interviews with the Owner, a Caregiver and three residents indicated residents could have food they wanted including food brought in from the outside and as long as it did not go against physician's orders. Review of physician's orders for seven residents did not document residents were on special diets. Allegation #5. A resident spent three months wearing only a diaper and white t-shirt was unsubstantiated based on observation of seven residents fully dressed and interviews with the Owner, a Caregiver, a Hospice Nurse and three residents who indicated residents were properly dressed each day. Allegation #6. A resident developed bed sores while in the facility was unsubstantiated based on observation of bedbound residents being turned/repositioned by staff and interviews with the Owner, a Caregiver, and a Hospice Nurse who indicated there were no residents in the facility who had developed pressure sores. Review of medical and hospice records, including the resident of concern revealed no residents had developed pressure sores. Allegation #7. A resident's personal items including cell phone, were locked away and kept out of the reach of resident. A resident was only allowed to make phone calls on the house phone while staff listened to their conversation was unsubstantiated based on observation of residents having access to their personal items, including cell phones			

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	and interviews with the Owner, a Caregiver, and three residents who indicated they had access to all of their belongings and could make phone calls in private when they wished to. Allegation #8. The facility removed the batteries from the remote control so a resident couldn't watch television (TV), was unsubstantiated based on observation of multiple residents watching TV and all remote controls working properly. Interviews with the Owner, a Caregiver, a Hospice Nurse and three residents revealed there were no issues with TV or remote controls working. Allegation #9. A resident was hit by staff and thrown to the floor was unsubstantiated based on observation of resident/staff interactions which showed no residents being hit by staff or thrown down, and interviews with the Owner, a Caregiver, a Hospice Nurse and three residents who indicated they had not observed staff members hitting or throwing down residents. Allegation #10. A resident who requested to go in the backyard was denied by staff was unsubstantiated based on observation of residents going outside and interviews with the Owner, a Caregiver and three residents who indicated they could go outside whenever they wanted. Allegation #11. A resident was forced to change their own brief after staff refused to assist was unsubstantiated based on observation of no odors in the facility, no residents in soiled briefs and interviews with the Owner, a Caregiver, a Hospice Nurse and three residents who indicated staff assisted in toileting and clean up when needed. Review of Activities of Daily Living tracking logs for eight residents, including the resident of concern documented cleaning and toileting assistance was conducted as needed. Allegation #12. A resident did not receive hygiene care was unsubstantiated based on observation of residents who appeared hygienically well taken care of and interviews with the Owner, a Caregiver, a Hospice Nurse and three residents who			

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	indicated hygiene care was provided as needed by both staff and hospice. Review of Activities of Daily Living tracking logs for eight residents, including the resident of concern documented hygiene care was provided for residents. Allegation #13. A resident was not allowed to leave their room for months and could not interact with other residents was unsubstantiated based on observation of residents in and out of their rooms, no doors being closed or locked and residents interacting with each other in the kitchen and living room. Interviews with the Owner, a Caregiver and three residents revealed residents were free to go anywhere in the facility and could interact with other residents as they pleased. Allegation #14. A resident walked through the bedroom of another resident to use the restroom was unsubstantiated based on observation of no residents going into the rooms of other residents and interviews with the Owner, A Caregiver and two residents with an attached bathroom in their room who indicated other residents did not come through their room. Allegation #15. A resident was forced to sleep on a mattress on the floor and the rooms were bare of furniture was unsubstantiated based on observation of resident rooms which revealed rooms had beds which were not on the floor, tables, nightstands and televisions. Interviews with the Owner, a Caregiver and three residents indicated there were no mattresses on the floors and there was ample furniture in the rooms to meet their needs. The investigation into the allegations included: -Observation of staff and resident interactions, resident to resident interactions, residents being attended to, resident hygiene, residents' appearance, food available and present in resident rooms, residents' access to personal belongings and cell phones, activities, working TVs, residents in and out of rooms, placement of beds and furniture in room, bathroom locations, environmental conditions and residents properly dressed. -			

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	Record review of eight resident records and hospice records, including the resident of concern, for documentation of injuries or unexplained condition changes, activities of daily living (ADL), Medication Administration Record, physician's orders and dietary requirements. -Record review of five employee files and documentation of disciplinary action. -Review of facility policy on abuse, ADL care and Changes of Condition. -Review of facility incident reports. -Interviews with a caregiver, the Owner, a Hospice Nurse and three residents. 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. A deficiency unrelated to the complaint was also identified.			

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0527 SS= F	Activities for Residents - NAC 449.260 Activities for residents. (NRS 449.0302) 1. The caregivers employed by a residential facility shall: (b) Provide group activities that provide mental and physical stimulation and develop creative skills and interests; Inspector Comments: Based on observation, interview and document review, the facility failed to provide activities which stimulated residents' interests and skill levels for 7 or 7 residents. Findings include: On 07/07/22 from 8:45 AM to 11:30 AM, there were no activities conducted. Seven residents were observed either in their room, in bed, watching television or sleeping. Review of the activity calendar for July 2022, documented daily activities would be conducted including exercise, puzzles and bingo. The daily activities listed on the calendar were not conducted. On 07/07/22 at 10:30 AM, three residents indicated being unaware of activities being offered at the facility. On 07/07/22 at 11:00 AM, the Owner acknowledged no activities were offered at the facility because the residents had no interest in doing them. Severity: 2 Scope: 3	0527	1. Administrator immediately instructed posting of the monthly schedule of activities so residents can easily refer to the schedule. Owner also reiterated to residents that there are daily activities that they can join and enjoy. 2. Administrator instructed preparation of two months schedule of activities so as to have enough time to plan and disseminate information. 3. Administrator will check if the monthly schedule of activities is posted in a conspicuous place, will also check if there's already a prepared schedule for the following month. 4. Administrator and owner will make sure plan of correction is implemented. 5. July 20, 2022. 6. Please see copies of July and August schedule of activities.	07/20/2022

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm system was activated on 2 of 3 doors exiting the facility. Finding include: On 07/07/22, throughout the morning, the audible alarm system on the front door and rear door was not functioning. Neither alarm activated when the door was opened. The Owner acknowledged the front door and the rear yard door alarms were turned off and should have been activated. Severity: 2 Scope: 3 This is a repeat deficiency.	0991	1. Owner right away instructed activation of said alarms. 2. Administrator came up with signages stating "Door alarm to be kept on at all times!." Signages will be posted next to each alarm. This will serve as a reminder to everyone. 3. Administrator and owner will do a random inspection of alarms. 4. Administrator and owner will make sure plan of correction is observed. 5. July 20, 2022 6. Please see pictures of posted signages.	07/20/2022