Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9545	A. BUILDING _____ B. WING _____	02/16/2023

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

(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 an annual state licensure and infection control survey initiated at your facility on 02/16/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files and three employee files were reviewed. The facility received a grade of A. 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 deficiency was identified:	0000		
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on observation, interview, and document review, the facility failed to maintain and/or post a written staffing schedule that included the staff assigned for each shift. There was no staffing schedule posted or available in the facility. On 02/16/2023 at 10:00 AM, a Caregiver verified there was no written staffing schedule posted and/or available at the facility. Severity: 1 Scope: 3	0088	1. Administrator right away instructed owner to make a written schedule. 2. Administrator requested owner to prepare a schedule to make sure 2 weeks are already covered. Owner is also in the process of hiring another staff to join the team. 3. Administrator will regularly check if there's a written schedule posted. 4. The Administrator is in charge of making sure the Plan of Correction is implemented. 5. February 16, 2023. 6. Please see attached copies of prepared schedule.	02/16/2023

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: ROSALLEN AZUCENA	Title: RFA	Date: 02/27/2023