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 _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND, LLC	**4354 E HARMON AVE, LAS VEGAS, NEVADA ,89121**

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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 and infection control survey conducted at your facility on 05/18/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease and/or chronic illness, five Category I residents and five Category II residents. The census at the time of the survey was eight. Eight resident files, one discharged resident file, and six employee files were reviewed. The census at the time of the survey was eight. The facility received a grade of D. One complaint was investigated. Verified 1. Complaint #NV00068393 was verified (See Tag's 0853 and 0923). The investigation of the complaint included: Observation of resident's skin condition and security of medications. Interviews were conducted with residents and Caregivers. Record review of nine resident records, including the resident of concern. Document review of incident reports. 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		
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for	0074	What measures will be put intoplace or what systemic changes you will make to ensure that deficient practicedoes not recur Elder abuse training wascompleted by employee #6 on 04/01/2023. How the facility will monitorits corrective actions to ensure that the deficient practice	04/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: TRINA M ANDERSON Title: Administrator Date: 07/25/2023

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	individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the		is being correctedand will not recur, i.e., what program will be put into place to monitor thecontinued effectiveness of the systemic change. All new hires moving forwardwill receive approved elder abuse training with first 2 days of training tocommunity. All findings to be reported to Administratorfor review	

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	training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such			

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	requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees had initial elder abuse training (Employee #6 was hired on 04/01/23 and lacked documented evidence of initial elder abuse training). The Caregiver reported initial elder abuse training had not been completed. Severity: 2 Scope: 1			

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0102 SS= E	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 6 employees had a pre-employment physical, a two-step tuberculosis (TB) test, or annual signs and symptoms (Employee #1 was hired on 04/11/20, the employee was missing a pre-employment physical and 2022 annual signs and symptoms. Employee #4 was hired on 09/25/18, the employee was missing 2022 annual signs and symptoms. Employee #6 was hired on 04/01/23 and lacked documented evidence of a two-step TB test). The Caregiver was unable to provide documented evidence of the missing physical examinations, annual signs and symptoms and TB tests. Severity: 2 Scope: 2	0102	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?** No residents have the potential for harm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Employee #1 physical and annual s/s obtained on 07/10/23. Employee #4 No no longer works at group home effective June 7, 2023. Employee #6 2-step tb initiated on 03/18/23 see attached **How will the facility monitor** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Personnel records will be reviewed prior to start date for completion of all required steps of employment with community. Individual(s) Responsible: Administrator/Owner	07/13/2023

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0106 SS= E	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 6 employees were trained in cardiopulmonary resuscitation (CPR) and first aid (Employee #4 (R4) was hired on 09/25/17, R4's CPR and first aid expired on 09/08/22. Employee #6 was hired on 04/01/23 and lacked documented evidence of CPR and first aid). The Caregiver was unable to provide documented evidence of CPR and first aid training. Severity: 2 Scope: 2	0106	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected bythe same practice and whatanticipated corrective action will be taken?** No residents have the potential forharm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** First aid and CPR for employees #4 and # 6obtained on 10/14/2022 & 03/19/2023 and placed in file see attached **How will the facility monitorits** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Personnel records will be reviewed priorto start date for completion of all required steps of employment withcommunity. Individual(s) Responsible:Administrator/Owner	03/19/2023

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview the facility failed to ensure the facility was well maintained as evidenced by: The kitchen cabinets had peeling paint and food debris on them. The vent next to the front door had heavy dust build-up. The Caregiver acknowledged the findings. Severity: 2 Scope: 3	0178	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?** All residents have the potential for harm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Vent and cabinets were cleaned and painted. Staff will do maintenance rounds weekly. Staff will inspect dining areas routinely for broken or missing items. **How will the facility monitor** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Administrator/designee will conduct kitchen rounds bi-weekly for any issues Individual(s) Responsible :administrator/designee	07/13/2023

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0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report contained the necessary information after an injury occurred for 1 of 9 residents (Resident #9). Findings include: Resident #9 (R9) R9 was admitted on 01/01/23 and discharged on 04/20/23, with diagnosis including hemiplegia and cerebral infarction. An undated incident report was documented on a folded up blank white piece of paper. The incident report documented when R9 was being transferred, R9 leaned and got a bruise on the neck. The incident report was unclear how the bruise occurred as it stated, "so we catch him by neck." On 05/18/23 in the morning, the Caregiver reported the incident should have been documented on the incident report form and included the witness, a more detailed description of the injury and how it occurred, the date and time the injury occurred, and who was notified of the incident. Severity: 2 Scope: 1 Complaint #NV00068393	0853	What corrective actions will beaccomplished for those residents found to have been affected by the deficientpractice. Administrator to ensure that allcurrent caregivers will be re-trainedand new hire will receive Inservice training on incident reports per communitypolicy to be completed by administrator/designee 06/16/2023. What measures will be put intoplace or what systemic changes you will make to ensure that deficient practicedoes not recur Incident report training to beprovided by Administrator/designee upon hire of caregiver. Bi-annual refresherto also be completed by Administrator/designee to keep all caregivers up todate on incident reporting. How the facility will monitorits corrective actions to ensure that the deficient practice is being correctedand will not recur, i.e., what program will be put into place to monitor thecontinued effectiveness of the systemic change. Administrator/designee toreview Inservice trainings periodically to ensure all current med techs havebeen through training for incident reports and appropriate documentation ofcompletion on file. All findings to be reported to Administratorfor review	06/12/2023

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 9 residents signed an ultimate user agreement for medications (Resident #3 was admitted on 03/16/23. The resident file was missing a signed ultimate user agreement for medications). The Owner was unable to provide documented evidence of the missing ultimate user agreement. Severity: 2 Scope: 1	0876	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected bythe same practice and whatanticipated corrective action will be taken?** All residents have the potential forharm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** User agreement for resident #3 obtained and placed infile **How will the facility monitorits** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Resident records will be reviewed prior admissionto ensure all required documents have been obtained. Individual(s) Responsible:Administrator/Owner	05/18/2023
0878 SS= F	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions	0878	What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice? **Medication review for all sited residents and MAR and medication reflecting of all current orders** How will you identify other residents having	07/13/2023

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	of the physician. 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 must be administered as prescribed by the physician. If a physician 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 (Previously Y 0879) (3) Note the change in the record maintained pursuant to 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 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, the 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 observation, record review, and interview, the facility failed to ensure physician orders were obtained, medication was on site and the Medication Administration Record matched the prescription labels on medications bottles for 7 of 9 residents (Resident #1, #2, #4, #5, #6, #7 and #8). Findings include: Resident #1 (R1) R1 was admitted on 07/27/22, with diagnoses of senile degeneration of the brain, hypertension, and chronic kidney disease. A physician's order dated 07/27/22, and the May 2023 Medication Administration Record (MAR) documented Metoprolol 50		the potential to be affected by the same practice and what anticipated corrective action will be taken? **An audit has been completed validating the orders for as medications have the medication available. Medication have been ordered or discontinued as directed by Health Care Provider.** What measures will be put into place or what systemic changes will you make to ensure that the deficient practice is being corrected and will not recur? **Administrator/designee will perform audit monthly x2months to ensure all orders are valid and correct.** How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? **Random medication cart audits will be conducted to validate active orders have the medication** available Individual responsible: administrator **and/or designee(s)**	

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	milligrams (mg), take one tablet by mouth twice a day. The medication bottle documented 50 mg, take one and a half tablets by mouth twice a day. There was no change order sticker on the medication bottle. A physician's order dated 07/27/22, and the May 2023 MAR documented Hydra1azine 25 milligrams (mg) take one tablet by mouth twice a day. The medication was not on site. A physician's order dated 07/27/22, and the May 2023 MAR documented Morphine 20 mg/milliliters (ml), take 0.5 ml under the tongue every two hours as needed (PRN) for pain. The medication was not on site. A physician's order dated 07/27/22, and the MAY 2023 MAR documented Lorazepam 2 mg/milliliters (ml), take 0.5 ml under the tongue every two hours as needed (PRN) for anxiety. The medication was not on site. A physician's order dated 04/24/23, and the medication bottle documented Clonidine 1 mg, take one tablet by mouth every day. The medication was not listed on the May 2023 MAR. The resident's medication bin had Loperamide 2 mg. Take two capsules by mouth after first loose stool then one capsule as needed (PRN) after each loose stool. There was no physician's order, and the medication was not listed on the MAR. Resident #2 (R2) R2 was admitted on 06/30/22, with a diagnosis of hypertension and hyperlipidemia. A physician's order dated 06/03/22, and the medication bottle documented Potassium 20 meq (milliequivalents), take one tablet by mouth every day. The May 2023 MAR did not match the physician order and documented Potassium was given twice a day. The Caregiver indicated the resident received the medication once a day. A physician's order dated 09/11/22, and the medication bottle documented Ondansetron 4 mg, take one tablet by mouth every six hours PRN for nausea/vomiting. The medication was not listed on the May 2023 MAR. A physician's order dated 06/07/22, and the medication bottle documented Senna Plus			

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	8.6-50 mg, take one tablet by mouth twice a day and hold for loose stool. The medication was not listed on the May 2023 MAR. The May 2023 MAR documented Eliquis 5 mg, take one tablet by mouth twice a day. The medication was not on-site and there was no physician order. Resident #4 (R4) R4 was admitted on 04/17/23, with diagnoses including diabetes and hypertension. A physician's order dated 04/17/23, and the May 2023 MAR documented Famotidine 20 mg, take one tablet by mouth every day. The medication was not on site. A physician's order dated 04/17/23, and the May 2023 MAR documented Nifedipine 90 mg, take one tablet by mouth every day. The medication was not on site. Resident #5 (R5) R5 was admitted on 04/26/23, with diagnoses including atrial fibrillation and heart disease. A physician's order dated 05/16/23, and the medication bottle documented Hydrocodone 5-325 mg, take one tablet by mouth every four hours PRN for pain. The medication was not listed on the May 2023 MAR. A physician's order dated 05/15/23, and the medication bottle documented Tramadol 50 mg, take one tablet by mouth every six hours PRN for pain. The medication was not listed on the May 2023 MAR. Resident #6 (R6) R6 was admitted on 11/03/22, with diagnoses including dementia and anxiety. A physician's order dated 04/26/23, and the medication bottle documented Quetiapine 25 mg, take one tablet by mouth every night at bedtime. The May 2023 MAR documented the medication was given at 8:00 AM every day. Resident #7 (R7) R7 was admitted on 12/20/22, with diagnoses including hypertension, acid reflux, and anemia. A physician's order dated 04/18/23, and the medication bottle documented Trazodone 150 mg, take one tablet by mouth every night at bedtime. The medication was not documented on the May 2023 MAR. A physician's order dated 04/11/23, and the medication bottle documented Oxycodone 5-325 mg, take			

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	one tablet by mouth every eight hours PRN for pain. The medication was not documented on the May 2023 MAR. A physician's order dated 03/31/23, and the medication bottle documented Thiamine 100 mg, take one tablet by mouth every day. The medication was not documented on the May 2023 MAR. A physician's order dated 04/11/23, and the medication bottle documented hydrochlorothiazide 12.5 mg, take one tablet by mouth every day. The medication was not documented on the May 2023 MAR. A physician's order dated 04/01/21, and the May 2023 MAR documented Lidocaine four percent patch, apply one patch daily 12 hours on 12 hours off. The medication was not on site and the May 2023 MAR was signed as given. A physician's order dated 11/27/22, and the May 2023 MAR documented Tamsulosin 0.4 mg, take one capsule by mouth every day. The medication was not on site and the May 2023 MAR was signed for as given. The May 2023 MAR documented Temazepam 15 mg, take one capsule by mouth at bedtime. The medication was not on site, there was no physician's order, and the May 2023 MAR was signed as given. The May 2023 MAR documented Vitamin D3, take one tablet by mouth every day. The medication was not on site, there was no physician's order, and the May 2023 MAR was signed as given. The resident's medication bin had Docusate 100 mg, take one tablet by mouth every 12 hours PRN for constipation. There was no physician's order, and the medication was not listed on the May 2023 MAR. The resident's medication bin had Imodium 2 mg, take two capsules by mouth after first loose stool then one capsule after every loose stool. There was no physician's order, and the medication was not listed on the May 2023 MAR. Resident #8 (R8) R8 was admitted on 02/11/23, with diagnoses including Alzheimer's disease and anxiety. The following medications were not documented as given on the May 2023 MAR and had no			

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	physician's order. Hydrocodone Escitalopram 20 mg, take one tablet by mouth twice a day. Memantine 10 mg, take one tablet by mouth twice a day. Carvedilol 25 mg, take one tablet by mouth twice a day. Hydroxyzine 10 mg, take one tablet by mouth at bedtime. The Caregiver was unable to explain why medications were not on-site or the medications were not listed on the May 2023 MAR. Severity: 2 Scope: 3			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured as evidenced by: The padlock on the laundry room door was not latched and contained resident medications. The Caregiver acknowledged the unsecured medications and reported they should have been locked up and not accessible to residents. Severity: 2 Scope: 3	0920	What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice? **Padlock will remain locked when medication room isempty.** How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken? **All residents have to potential for harm** What measures will be put into place or what systemic changes will you make to ensure that the deficient practice isbeing corrected and will not recur? **Medication room will be remained padlocked while not inuse** How will the facility monitor its corrective actions to ensure that the deficientpractice is being corrected and will notrecur? **Staff educated on 05/18/2023 while not using med room to keep room lockedat all times** Individual responsible: Administrator **and/or designee(s)**	05/18/2023

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were kept in its original container as evidenced by: On top of the dryer there was one medication cup which contained three pills. The Caregiver reported the resident often refused to take their medications so the caregiver would try again later. The Caregiver reported the medications in the cup were placed there until the Caregiver's next attempt to administer the medication. Severity: 2 Scope: 1 Complaint #NV00068393	0923	What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice? **No resident was affected by the practice at the time ofthe survey.** How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken? **All residents have the potential to be harmed.** What measures will be put into place or what systemic changes will you make to ensure that the deficient practice isbeing corrected and will not recur? **Staff in-serviced on proper storage of medication afterrefusal of medication**. Medications arenot to be pre poured prior to administration of medications. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? **Staff educated on not pre pouring medications prior toadministration. Educated on the six rights of medication administration.** Individual responsible: Administrator**and/or designee(s).**	06/04/2023

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0936 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 5 of 9 residents had a two-step tuberculosis (TB) test (Resident #1 was admitted on 07/27/22 and was missing a two-step TB test, Resident #2 was admitted on 06/30/22 and was missing a two-step TB test, Resident #4 was admitted on 04/17/23 and was missing a two-step TB test, Resident #5 was admitted on 04/26/23 and was missing a two-step TB test, and Resident #8 was admitted on 02/11/23 and was missing a two-step TB test). The Owner was unable to provide documented evidence of the missing TB tests. Severity: 2 Scope: 3	0936	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?** No residents have the potential for harm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Full chart audit completed on 7/23/23. All residents sited TB obtained and placed in file. Residents will have a 2 step TB test if negative, or QuantIFeron will be obtained, if positive shows X-ray will be obtained. **How will the facility monitor corrective actions to ensure that the deficient practice is being corrected and will not recur?** Resident records will be reviewed prior to admission to ensure all required documents are with community. Before move in residents will receive a 2 step TB test to rule out TB. If first TB test shows positive, resident will get x-ray to rule out TB. All test and or x-ray's will be placed in resident chart. Responsible: Administrator/Owner	07/23/2023

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0938 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure 5 of 9 residents had an activities of daily living (ADL) assessment (Resident #1 was admitted on 07/27/22 and was missing an ADL assessment, Resident #2 was admitted on 06/30/22 and was missing an ADL assessment, Resident #4 was admitted on 04/17/23 and was missing an ADL assessment, Resident #5 was admitted on 04/26/23 and was missing an ADL assessment, and Resident #8 was admitted on 02/11/23 and was missing an ADL assessment). The Owner was unable to provide documented evidence of the missing an ADL assessments. Severity: 2 Scope: 3	0938	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected bythe same practice and whatanticipated corrective action will be taken?** No residents have the potential forharm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Full chart audit completed on 5/20/23. Allresidents sited evaluation obtained and placed in file. **How will the facility monitorits** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Resident records will be reviewed prior toadmission to ensure all required documents are with community. Individual (s) Responsible:Administrator/Owner	05/20/2023

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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 the back door alarm was operating. The Caregiver acknowledged the back door alarm did not sound and was unaware how to change the batteries. Severity: 2 Scope: 3	0991	What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice? **No resident was affected by the practice at the time ofthe survey.** How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken? **All residents have the potential to be harmed.** What measures will be put into place or what systemic changes will you make to ensure that the deficient practice isbeing corrected and will not recur? **Alarm placed and tested on day of survey** How will the facility monitor its corrective actions to ensure that the deficientpractice is being corrected and will notrecur? **Staff willconduct weekly test on back alarm weekly x 2 weeks and then periodically x 2months. Administrator or designee will conduct test weekly x 4 weeks thenperiodically x 3 months** Individual responsible: Administrator**and/or designee(s).** Date of completion	05/18/2023

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0994 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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp objects were secured as evidenced by: The lock on the cabinet under the kitchen sink was broken which contained unsecured knives. The padlock on the laundry room door was not latched and contained unsecured scissors. The Caregiver acknowledged the unsecured sharp objects and reported they should have been locked up and not accessible to residents. Severity: 2 Scope: 3	0994	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **No residents were affected by this action at the time of survey.** How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken? **All residents have the potential for harm.** What measures will be put into place or What systematic changes will you make to ensure that the deficient practice isbeing corrected and will not recur? **Cabinets in the area have been secured. The access door to the area has been locked and only staff with key access can open the door. Staff have been in-services on safety and proper storage and use of dangerous items.** How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? **At change of shift staff will inspect area for dangerous items.** **review of audits biweekly for three months. Individual(s) Responsible: Administrator and designee**	07/13/2023

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0999 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: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured as evidenced by: The padlock on the laundry room door where medications were stored was repeatedly not latched when the Caregiver left the room multiple times. The Caregiver acknowledged the unsecured medications and reported they should have been locked up and not accessible to residents. Severity: 2 Scope: 3	0999	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **No residents were affected by this action at the time of survey.** How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken? **All residents have the potential forharm.** What measures will be put into place or What systematic changes will you make to ensure that the deficient practice isbeing corrected and will not recur? **The access door leading into the medication area is locked and must be accessed by staff only with a key. Staff have been in-serviced as the proper use, storage, and safety of locking med roomdoor.**	05/19/2023

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1035 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees had two hours of initial Alzheimer's training(Employee #6 was hired on 04/01/23 the employee file lacked documented evidence of the initial two hour Alzheimer's training within the first 40 hours of employment). The Caregiver reported Alzheimer's training had not been completed. Severity: 2 Scope: 1	1035	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected bythe same practice and whatanticipated corrective action will be taken?** No residents have the potential forharm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Alzheimer’s training completed for all employeesited on 04/08/23 **How will the facility monitorits** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Personnel records will be reviewed prior tostart date for completion of all required steps of employment withcommunity. Individual(s) Responsible:Administrator	04/08/2023
1037 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is	1037	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected bythe same practice and what anticipated corrective action will be taken?**	01/10/2023

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	licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees had three hours of annual Alzheimer's training by date of hire (Employee #3 was hired on 01/02/22 and lacked documented evidence of three hours of annual Alzheimer's training). The Caregiver reported annual Alzheimer's training had not been completed for Employee #3. Severity: 2 Scope: 1		No residents have the potential forharm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Alzheimer's annual training completed for allemployee sited on 01/10/23 **How will the facility monitorits** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Personnel records will be reviewed priorto start date for completion of all required steps of employment withcommunity. Individual(s) Responsible:Administrator/Owner **Date of completion:**	

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 _____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND, LLC	**4354 E HARMON AVE, LAS VEGAS, NEVADA ,89121**

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1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on record review and interview, the facility failed to post a non-discrimination sign in the facility and ensure staff were trained in cultural competency for 5 of 6 employees (Employee #1 was hired on 04/11/20, Employee #2 was hired on 10/23/18, and Employee #3 was hired on 01/02/22, Employee #4 was hired on 09/25/17, Employee #6 was hired on 04/01/23). The Caregiver acknowledged the missing cultural competency training and was unable to provide the nondiscrimination sign. Severity: 2 Scope: 3	1540	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this action at the time of survey. **How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken?** No residents have the potential for harm. **What measures will be put into place or What systematic changes will you make to ensure that the deficient practice is being corrected and will not recur?** Cultural competency training completed for all employees. Employee #4 no longer works at the group home effective 6/7/23. **How will the facility monitor** **corrective actions to ensure that the deficient practice is being corrected and will not recur?** Personnel records will be reviewed prior to start date for completion of all required steps of employment with community.	07/13/2023