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 _____	**09/20/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT NIGHTINGALES	**813 FAIRWAY DRIVE, LAS VEGAS, NEVADA ,89107**

(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 Infection Control, Complaint Investigation Survey and State Licensure annual grading survey initiated at your facility on 09/20/21 and completed on 09/21/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Groups beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, Category II residents. The census at the time of the survey was ten. Ten resident and six employee files were reviewed. The facility received an annual survey grade of A. One complaint was investigated. Complaint #64836 with three allegations was unsubstantiated. Allegation #1 - The caregivers are physically and verbally abusive and have used a paddle several times on a client was unsubstantiated based on interviews with the residents and caregivers. Observations of residents showed no evidence of unusual marks or bruising. Staff and resident interactions showed no signs or evidence of physical or verbal abuse. Allegation #2 - The resident was given a double dose of medication was unsubstantiated based on interviews with the resident of concern and caregivers, review of medication administration records and medications. Observation of medication administration record and medications showed no evidence of medication dosage mistakes. Allegation #3 - The facility only provides processed/ junk food to residents was unsubstantiated based on interviews with the residents and caregivers, observation of menu and lunch being prepared. Observation of menu and groceries available in facility showed healthy food was being prepared and served daily. The investigation into the allegations included: Observations of staff	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ANNE ESPINUEVA Title: Managing Member Date: 10/11/2021

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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	to resident interactions. Interviews with seven residents, two caregivers, and the owner. Record review of ten resident files including the resident of concern. Document review of incident reports. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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 deficiencies were identified:			

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0392 SS= F	Safety Requirements - NAC 449.226 Safety requirements for residents with restricted mobility or poor eyesight; water hazards; auditory systems for bathrooms and bedrooms; access by vehicles. (NRS 449.0302) 3. If a residential facility with a resident who is mentally or physically disabled has a fishpond, pool, hot tub, jacuzzi or other body of water on the premises of the facility, the body of water must be fenced, covered or blocked in some other manner at all times when it is not being used by a resident. Inspector Comments: Based on observation and interview, the facility failed to ensure a pool was secured. Findings include: On 09/20/21, at approximately 9:00 AM during a tour around the premises of the facility, a pool was observed surrounded by fencing, the gate to the pool was unlocked. On 09/20/21, at approximately 11:00 AM, the Owner verbalized the gate leading to the pool was supposed to be secured and locked. Severity: 2 Scope: 3	0392	Facility pool have fence but caregiver failed to locked the gate to the pool after morning maintenance during the day of inspection on September 20, 2021. A corrective action plan is discussed with caregivers to ensure pool is locked at all times. After daily pool cleaning and maintenance, gate must be secured and locked. See attached photo documentation of locked pool gate.	09/20/2021

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0936 SS= D	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 1 of 10 residents had an initial two-step tuberculosis test (TB)(Resident #2 - admitted 01/31/20). Resident #2 had a signs and symptoms review dated 12/06/19 and a chest x-ray dated 12/06/19. Resident #2 did not have a positive TB test in his file. The Administrator was unable to provide documented evidence Resident #2 received an initial two-step TB test or a positive TB test. Severity: 2 Scope: 1	0936	Resident # 2 was admitted from Rawson-Neal Mental Hospital. Resident had a reported positive history of TB skin test but no copy of actual TB skin test result was obtained since patient was from Florida. A chest x ray was done on 12/06/2019 and active pulmonary tuberculosis was ruled out. A copy of documentation of positive history of TB skin test (Exhibit A) is in the chart, chest x-ray (Exhibit B) and a yearly signs and symptoms review (Exhibit C) was done annually by At Nightingales facility is present in the chart during annual inspection. A quantiferon TB test was done on Resident # 2 on 8/9/2021 and result is negative (see Exhibit D for result).	09/21/2021