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 _____	**12/22/2021**

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 a Complaint Investigation conducted at your facility on 12/22/21 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 eight. The sample size was five. The facility received a grade of A. One complaint was investigated. Complaint #65351 with five allegations was not substantiated. Allegation #1: Caregivers were hitting residents with a paddle could not be substantiated based on observations of the residents' shins, arms, heads, and faces which appeared without unusual marks or bruises and did not indicate residents were being hit. Interviews with seven residents who explained the staff had never hit them. Interview with a Registered Nurse who visited the facility twice a week and indicated they had not witnessed the staff hit any of the residents. Interview with a caregiver and the owner who explained the staff had not hit the residents. Allegation #2: A resident received the wrong dosage of Vitamin D was not substantiated based on a review of a change order from the resident's physician which changed the dosage of Vitamin D in October 2021. Review of the October 2021 Medication Administration Record (MAR) matched the change in the prescription for Vitamin D to the new dosage. Interviews with eight residents who explained the staff have provided the residents with the right medications and dosages. A medication review of five resident medications compared to their MARs which indicated the facility was providing the medications to the residents per physician's orders. Allegation #3: A resident was improperly discharged	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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.

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 _____	**12/22/2021**

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
	was not substantiated based on review of the facility's rules and incident reports which indicated a resident was consistently violating the facility rules which the resident had signed upon admission. Interviews with the owner who indicated the resident and the owner mutually agreed to discharge the resident to a new assisted living facility, per the regulatory requirements. Allegation #4: A caregiver emotionally abused residents by using expletives and calling a resident retarded was not substantiated based on interviews with eight residents who denied the caregivers had called the residents names or used expletives when speaking with the residents. An interview with a Registered Nurse who was in the facility two times per week who explained they had not witnessed caregivers calling the residents names or using expletives. Interviews with a caregiver and the Owner who denied staff called the residents names or used expletives towards the residents. Allegation #5: A resident was locked outside the facility after police were called was not substantiated based on interviews with eight residents who explained they had not been locked outside the facility at any time during their admission. Interviews with a Registered Nurse who was in the facility twice a week and explained not having witnessed or heard reports of residents being locked outside the facility. Interviews with a caregiver and the Owner who denied staff had locked residents out of facility. The investigation into allegations included: Observations of the residents' shins, arms, heads, and faces. Observations of the caregivers and owner assisting and speaking with the residents. Record review of five resident's MARS, five resident files, one discharged resident's file, and all incident reports for the previous six months. Interviews with eight residents, a Registered Nurse, a caregiver, and the Owner. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as			

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 _____	**12/22/2021**

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
	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. There were no deficiencies identified. Please retain a copy of this notice for your records.			