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
	9724	A. BUILDING _____ B. WING _____	09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA CARE HOME, LLC	**9900 VERMILLION CLIFFS AVE, LAS VEGAS, NEVADA ,89147**

(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 conducted at your facility on 09/13/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility was licensed for eight Residential Facility for Group beds for 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 B. 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 regulatory deficiencies were identified:	0000		

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: ROBERT MARTINEZ Title: Administrator Date: 10/02/2021

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation and interview, the facility failed to implement safe infection control practices for the protection of residents in response to the COVID-19 pandemic. Findings include: On 09/13/21 at 8:00 AM, three employees were not wearing a face mask. At 8:20 AM, the Owner arrived at the facility and was not asked COVID-19 screening questions related to symptoms, travel history, and exposure to the virus. A temperature check was not performed prior to being allowed entry to the facility. The Administrator verbalized all visitors and employees should have been screened for temperature checks and questions related to COVID-19 symptoms. The Administrator indicated the three employees should have been wearing a face mask. Severity: 2 Scope: 3	0050	1.) Deficiency will be corrected by conducting a meeting with Administrator, Ownership, and Staff on the State requirements for COVID evaluations done for every visitor to the facility. 2.) Administrator will reinforce with Ownership and Staff that COVID evaluations must be done for every visitor. These include a.) temperature checks b.) flu-like symptom evaluations c.) facility members must wear masks and ensure visitors are wearing masks as well d.) logging in visitor temperatures in the log book 3.) Administrator will conduct the COVID evaluation process with Staff upon each visit by the Administrator. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 9/14/21	09/14/2021
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 exterior of the facility was maintained. Findings include: On 09/13/21 at 11:30 AM, the following were observed: -The backyard had multiple unused pieces of medical equipment. -The grass had scattered patches of brown and yellow color. The Administrator and Owner acknowledged the backyard was not properly maintained. Severity: 2 Scope: 3	0178	1.) Deficiencies will be corrected by clearing the side of the house of unnecessary equipment and to water the lawn. 2.) Administrator and Ownership will conduct regular evaluations of the backyard to ensure compliance with State regulations. 3.) Administrator will conduct inspections of the backyard to ensure compliance with State regulations, and inform Ownership in the event that the backyard is potentially out of compliance. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 9/15/21	09/15/2021

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on interview and record review, the facility failed to ensure a resident who was bedfast and required a urinary catheter was not admitted and retained (Resident #8). Findings include: Resident #8 (R8) R8 was admitted to the facility on 07/30/21 with diagnoses including multiple sclerosis. The resident was under the care of a Hospice agency. On 09/13/21 at 8:10 AM, during a tour of the facility R8 was observed lying in bed, with a urinary catheter. The Owner verbalized R8 required total care and was not able to reposition self without the assistance of staff. The Administrator acknowledged the facility had not requested the required exemption waiver for approval to admit and retain a bedfast resident. The Administrator indicated being unaware a resident required an exemption waiver for a urinary catheter. Severity: 2 Scope: 1	0620	1.) Deficiency will be corrected by turning in an Exemption Waiver to the Department of Public and Behavioral Health for Resident #8. 2.) Administrator will conduct regular evaluations of residents needing exemption waivers by personally checking on residents and conferring with Staff and Ownership on each resident's condition and if an Exemption Waiver is needed. 3.) Administrator will conduct checks once each month, and will be available to be contacted at anytime by Staff or Ownership in order to do an Exemption Waiver if needed for a resident. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 10/2/21	10/02/2021

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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 2 doors exiting the facility. Finding include: On 09/13/21, at 8:00 AM, during a tour of the facility, two audible alarm systems on the exit doors leading to the front and backyard were not activated. The Caregiver acknowledged the two alarms were not turned on. The Owner acknowledged the two exit door alarms were not turned on. The Owner indicated both exit doors alarms needed a battery replaced. Severity: 2 Scope: 3	0991	1.) Deficiency will be corrected by installing new door alarms for both the front entrance and rear exit (pics attached). 2.) Administrator and Ownership will implement regularly scheduled checks of the door alarms to ensure full functionality. 3.) Administrator and Ownership will meet with staff to inform them of the implementation of regular door alarm checks, as well as having them contact the Administrator or Ownership in the event a door alarm is non-functional or broken. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 9/14/21	09/14/2021