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 _____	**04/06/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASI SPENCER	**4148 SPENCER STREET, LAS VEGAS, NEVADA ,89119**

(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 the State Licensure Complaint Investigation survey conducted at your facility on 04/06/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for 40 Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, and/or persons with chronic illness, and/or persons with intellectual disabilities, Assisted Living Services, 10 Category I residents and 30 Category II residents. The census at the time of the survey was 36 residents. Three resident records were reviewed. Two complaints were investigated: Complaint #NV00065875 with one allegation was unsubstantiated. Allegation #1: The facility is performing inappropriate therapy services on-site was unsubstantiated based on observation of contracted therapists providing services at the facility, and interviews with the Administrator, the Care Coordinator, an Occupational Therapist, and two Caregivers, who reported facility staff did not perform physical therapy on site. Review of three residents records revealed the physical therapy services were provided by a licensed contracted therapist. The investigation into the allegation included: Observations, interviews with an Occupational Therapist, the Administrator, two Caregivers, and the Care Coordinator, and record reviews of three residents, including Admission Agreements showing the resident was responsible for furnishing or paying for health and medical care services, including rehabilitative therapies. Complaint #NV00065909 with two allegations was unsubstantiated: Allegation #1: A resident sustained a seizure in the dining area, was left unsupervised for hours, fell out of the wheelchair, and was left laying on the ground until another	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.

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	resident yelled for help was unsubstantiated based on interviews with two food service staff, the Administrator, the Occupational Therapist, and the Care Coordinator, who reported the resident was appropriately assisted after sliding out of the wheelchair, and review of the staffing schedule, which documented seven Caregivers and two food service staff were available on the date and time of the incident. Review of the current staffing schedule, tour of facility, and observation of lunch service in the dining room revealed there were five Caregivers and two food service staff available. Allegation #2: Staff left residents unattended and were not attentive was unsubstantiated based on observation of residents receiving care and assistance, a ratio of five staff members to 36 residents, and interviews with two residents, who reported staff were attentive to their service needs. There was no evidence of lack of care or lack of supervision. The investigation into the allegations included: Observations, tour of the facility, staff interviews, resident interviews, record review of three residents, including the resident of concern, and document review of an incident report and staffing schedules. 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:			