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 _____	**08/08/2022**

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 a complaint investigation completed at your facility on 08/08/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility 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 sample size was five. The facility received a grade of A. One complaint was investigated. Complaint #NV00066701 with two allegations was substantiated. Allegation #1: The facility was unable to lower a wheelchair ramp to evacuate a resident from the vehicle when the vehicle broke down was substantiated. (See Tag 0050) Allegation #2: The facility failed to properly inspect and maintain their vehicle for safety was unsubstantiated based on review of local mechanic invoices which indicated the vehicle had been service and inspected in 07/2022 and 04/2022. Interviews with a Clinic Assistant who explained the staff performed an exterior and interior inspection of the vehicle prior to driving the vehicle. Interviews with the Site Manager who explained the vehicles were serviced by an auto shop quarterly. Observation the vehicle was functioning and did not have signs of mechanical dysfunction. The investigation into the allegation included: Observations the vehicle and wheelchair ramp were functioning without malfunctions. Interviews with a Clinic Assistant, the Care Coordinator, and the Site Manager. Documentation review of incident reports from June, July and August 2022, mechanic maintenance reports from April 2022 and July 2022, and the facility transportation policy. The findings and conclusions of any investigation by the Division of Public and	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: SHELLE SPONSELLER | Title: Administrator | Date: 09/01/2022

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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	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 deficiency was identified.			
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, document review, and interview the facility failed to ensure a staff member was proficient in operating a vehicle's wheelchair ramp manually in case of emergency. Findings include: A review of Resident #1's file revealed the resident was admitted to the facility on 06/24/22 with diagnoses of impaired memory, delayed responses and comprehension. The resident's file indicated the resident required a wheelchair for mobility. A review of an incident report dated 07/12/22, written by Employee #1, revealed the following: Employee #1 transported Resident #1 to their doctor appointment on 07/12/22. At 11:57 AM, Resident #1 completed their doctor appointment and Employee #1 loaded Resident #1 into the facility shuttle bus to transport the resident back to the facility. While attempting to leave the parking lot Employee #1 heard the engine make a strange noise. Employee #1 turned off the engine and observed some smoke coming from the engine. Employee #1 had to lower the wheelchair ramp manually since they had turned the engine off. When Employee #1 tried to lower the ramp manually the ramp would not move. Employee #1 lowered the windows of the	0050	1) A Van Safety and Transportation Training has been developed and implemented and will be provided to all staff prior to transporting individuals from our community. 2) All staff must complete all elements of the training checklist and be approved by a Supervisor or Administrator. Documentation of the training will be maintained in the individual supervisory file on site. No staff will be permitted to transport individuals until training is completed. 3) Supervisor of the community will maintain an up-to-date list of all trained drivers and will assure that no one is given consent to transport individuals until training is complete. 4) Administrator will assure during routine and impromptu QA Reviews that all drivers are signed off and certified as trained to provide transportation. 5) 8/13/2022 6) Certificate of Completed Training for Staff #1; Checklist and Training Elements for Van Safety Training 7) Transportation will be discussed in all client forum meetings and all staff meetings; needs and concerns will be immediately addressed. Refresher training will be provided through out the year to assure acuity of skills	09/01/2022

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	shuttle bus as the temperature inside the vehicle had started to rise. Employee#1 called the Clinical Manager who advised Employee #1 to call 911. Employee #1 indicated Resident #1 expressed Resident #1 complained it was getting hot on the shuttle bus. The local Fire Department was able to evacuate Resident #1 without incident and Resident #1 returned to the facility in a family member's vehicle. On 08/08/22 in the morning, Employee #1 confirmed on 07/12/22 the engine in the facility vehicle experienced a malfunction. Employee #1 explained they turned off the engine and attempted to lower the wheelchair ramp manually. Employee #1 explained it was over 100 degrees Fahrenheit outside and Employee #1 was unable to lower the ramp. Employee #1 explained the temperature was hot outside, and Employee #1 was unable to turn on the air conditioning in the vehicle, because the engine was turned off. On 08/08/22 in the morning, the surveyor observed a wheelchair ramp was installed in a van. Employee #1 demonstrated they were able to lower the wheelchair lift when the engine was on. The Clinical Manager demonstrated lowering and raising the wheelchair lift manually. Employee #1 was unable to demonstrate they could lower or raise the wheelchair ramp manually. On 08/08/22 in the morning, the Site Manager explained the vehicle was taken to the mechanic on 07/12/22 and the wheelchair ramp was inspected. The mechanic could not detect any malfunction in the wheelchair ramp. The Site Manager acknowledged Employee #1 could not demonstrate how to lower or raise the wheelchair ramp manually. Severity: 2 Scope: 1 Complaint# NV00066701			