

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9883	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS MEMORY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8920 LOGGERS MILL AVE, LAS VEGAS, NEVADA ,89143		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey and infection control survey conducted at your facility on 11/15/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight beds for elderly and disabled and/or persons with chronic illness, Category II residents. The census at the time of survey was five. Five resident files and two employee files were reviewed. The facility received a grade of A. 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 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.			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9883	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS MEMORY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8920 LOGGERS MILL AVE, LAS VEGAS, NEVADA ,89143		
(X4) ID PREFIX TAG 0050 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 interview and employee record review, the facility failed to ensure infection control practices were implemented and maintained in response to the COVID-19 pandemic. Findings include: On 11/15/21 at 10:45 AM, the facility had no N95 masks and no employees were medically cleared and fit tested to wear an N95 mask. The Caregiver acknowledged no employees were medically cleared and fit tested to wear an N95 mask. Severity: 2 Scope: 3	ID PREFIX TAG 0050	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1) Head caregiver to attend training class for N95 training. Certificate of training to be sent once completed 2) Entire staff will be trained once #1 is complete and scheduled annually 3) Administrator will monitor 4) Administrator 5) 11/30/2021	(X5) COMPLETION DATE 11/30/2021

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9883	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS MEMORY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8920 LOGGERS MILL AVE, LAS VEGAS, NEVADA ,89143		
(X4) ID PREFIX TAG 0920 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the- counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure all medications were stored securely and inaccessible to residents. Findings include: On 11/15/2021 at 9:00 AM, during a facility tour, the following was observed: - A medication cabinet in the dining area was observed unlocked and accessible to residents. - Two tubes of the medication Zinc Oxide ointment and four bottles of saline were found in a bathroom cabinet. The Caregiver acknowledged the medication cabinet and medications found in the bathroom cabinet were unlocked and not secured. The Caregiver indicated the medication cabinet and medications found in the bathroom cabinet should have been locked and secured. Severity: 2 Scope: 3	ID PREFIX TAG 0920	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1) Additional training of staff 2) All medications to remain in locked cabinet at all times. There will be no medication stored in other places in the home 3) Head caregiver and Administrator 4) Administrator 5) 11/15/2021	(X5) COMPLETION DATE 11/15/2021