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 _____	**03/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS MEMORY CARE, LLC	**8920 LOGGERS MILL AVE, LAS VEGAS, NEVADA ,89143**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of the State Licensure Complaint Investigation survey initiated at your facility on 03/24/22 and concluded on 03/25/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for eight Residential Facility for Group beds with endorsements for elderly or disabled persons and/or persons with chronic illnesses, Category II residents. The census at the time of the survey was six. The facility received a grade of B. One complaint was investigated: Complaint #NV00065934 with four allegations was substantiated: Allegation #1: Protective supervision was not provided to a resident was substantiated. See TAG Y515. Allegation #2: The facility did not have awake staff at night was substantiated. See TAG Y515. Allegation #3: A resident left the room at night and was yelling at another resident, using profanity, and physically struck the resident on the legs was substantiated. See TAG Y515. Allegation #4: The facility put up a child's gate in front of a resident's room to keep the resident from from getting out and wandering was not substantiated based on observation of no child gate present at the facility, and interview with the Facility Manager and two Caregivers, who reported a child gate was not used. There was lack of evidence a child gate was put in front of a resident's room. 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:	0000		
0515 SS= I	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of	0515	1) The home was not prepared to accept this resident with her stated diagnosis.	05/04/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: LAWRENCE OSHEA Title: Administrator Date: 05/04/2022

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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	residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on interview, record review, and document review, the facility failed to ensure residents were provided with protective supervision as necessary and Caregivers were informed of the required supervision for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 07/25/20 with diagnoses including dementia and depression. The Physician's Statement dated 09/08/21 documented R1 had cognitive impairment and unsafe ambulation. The Physician's Standard Placement Determination dated 12/22/22 documented R1 had diagnoses including dementia, insomnia, depression, had an unsteady gait, was alert and oriented to self only, and was confused. The Activities of Daily Living (ADL) Assessment dated 01/25/22 documented R1 was not oriented and was not able to follow instructions. Incident Reports documented the following incidents: -02/22/22: R1 had an incident of combative behavior and pushed a Caregiver when attempting to redirect the resident. -02/24/22: R1 had an incident of combative behavior and pushed a Caregiver when trying to assist with eating. The Incident Report documented other residents told the Caregiver R1 went to their room and grabbed their things, and hit self, which was why R1 had bruises. R1 took off clothes and wanted to be completely nude. -02/27/22 at 2:30 AM: R1 was found in Resident #6's (R6's) bed. -03/03/22 at 11:00 PM: R1 hit Resident #3 (R3) on the legs. On 03/24/22, R3 verbalized being attacked by R1 the night of 03/03/22. R3 indicated R1 came into the room, was yelling and cursing, and kept shouting for R3 to get out of the room, the room belonged to R1. R1 hit R3 repeatedly on the legs. R3 indicated		Although the home is currently waiting for an Alzheimer endorsement the staff was not prepared. Until the endorsement is received and staffing properly set we will not accept a new resident with dementia, regardless of a physicians standard placement determination. 2) The managing caregiver will present all potential resident information to the administrator who will make the final determination regarding acceptance. 3) Multiple checks of potential resident files. 4) Administrator 5) 03/25/2022	

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	yelling repeatedly at R1 to leave the room. R3 indicated R3 still had leg pain due to the attack. R3 indicated staff members scheduled for the night did not wake up during the incident. R3 verbalized being concerned there were no Caregivers available at night to intervene, and R1 would come into the room again and attack R3. On 03/24/22, R6 indicated R1 frequently came in to R6's room at night and laid down on the bed. On 03/24/22, the Caregiver verbalized R1 was very confused, combative, and difficult to redirect at times. The Caregiver acknowledged the incidents of combative behavior and verified R1 had incidents of hitting self and taking off clothes when agitated. On 03/24/22, another Caregiver and the Facility Manager indicated R1 had several incidents of waking up in the middle of the night and wandering into other residents' rooms. The Facility Manager and the Caregiver confirmed there were no awake staff scheduled on the overnight shift to provide monitoring or supervision to R1 the night R1 wandered into R3's bedroom and hit R3 on the legs. The Caregiver indicated finding out about the incident upon awakening the following morning after R3 informed the Caregiver of the incident. On 03/24/22, the Facility Manager indicated the facility currently did not have staff members scheduled to be awake on the overnight shift to provide monitoring and supervision to R1. The Facility Manager acknowledged R1 was confused, had an unsteady gait, still woke up frequently in the middle of the night, and was difficult to redirect. On 03/25/22, the Administrator verified there were no awake staff at night to provide supervision and monitoring for R1. It should be noted, on 10/12/21, a deficient practice was identified due to the facility retaining a resident with a diagnosis of Alzheimer's disease or dementia related illness and lacking an Alzheimer's endorsement. This deficient practice referenced an incident whereby R1 was injured while exhibiting			

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	exit-seeking behaviors. The facility submitted an application for an Alzheimer's endorsement on 11/21/21 and retained R1 at the facility, pending approval for the Alzheimer's endorsement. Although the facility submitted an application for an Alzheimer's endorsement, from 10/12/21 to 03/24/22, there was no documented evidence the facility adjusted R1's plan of care, to address R1's exit-seeking and aggressive behaviors. Additionally, there was no documented evidence the facility adjusted the staffing schedule to provide for additional staff to provide protective supervision to all residents. On 03/24/22, the Facility Manager and the Administrator acknowledged they did not adjust the staffing schedule to provide for 24 hour awake staff and did not adjust R1's plan of care. Severity: 3 Scope: 3 Complaint #NV00065934			
0810 SS= D	Protective Supervision - NAC 449.2732 Residents requiring protective supervision. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a person who requires protective supervision may not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is able to follow instructions; (b) The resident is able to make his or her needs known to the caregivers employed by the facility; (c) The resident can be protected from harming himself or herself and other persons; and (d) The caregivers employed by the facility can meet the needs of the resident. Inspector Comments: Based on observation, interview, and record review, the facility failed to develop and implement a behavior policy in response to 1 of 6 sampled residents who required protective supervision (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 07/25/20 with diagnoses including dementia and depression. The Physician's Statement dated 09/08/21 documented R1 had cognitive impairment and unsafe	0810	1) Policies and procedures regarding the care of residents with Alzheimer's will be reviewed with the staff. Training in the care of Alzheimer's residents will be conducted. 2) TRAINING 3) Monitored by the administrator 4) Administrator 5) 05/01/2022	05/04/2022

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	ambulation. Hospital Emergency Department reports dated 09/03/21, documented R1 had a fall at the facility while trying to elope and sustained multiple injuries. The Physician's Standard Placement Determination dated 12/22/22, documented R1 had diagnoses including dementia, insomnia, depression, had an unsteady gait, was alert and oriented to self only, and was confused. The Activities of Daily Living (ADL) Assessment dated 01/25/22, documented R1 was not oriented and was not able to follow instructions. Incident Reports documented R1 had combative behaviors toward Caregivers on 02/24/22 and 02/26/22, was found in another resident's bed on 02/27/22, and entered another resident's room at 11:00 PM on 03/03/22, hitting the resident on the legs. On 03/24/22, the Facility Manager verified the incidents of R1's combative behavior and wandering occurred. The Facility Manager and the Administrator confirmed R1 was confused, had incidents of wandering overnight, had aggressive behaviors, and was difficult to redirect. There were no written policies regarding behavior management, elopement, and staffing plan for persons with diagnoses of Alzheimer's disease and/or related dementia. On 03/24/22, the Facility Manager and the Administrator verified they had not developed and implemented policies for the protection of persons with diagnoses of Alzheimer's disease and/or related dementia, such as policies for behavior management, prevention of and response to elopement, and a 24-hour awake staffing plan. The Facility Manager indicated they were waiting to get the approval for the Alzheimer's endorsement before developing policies and hiring 24 awake staff. Severity: 2 Scope: 1			
0840 SS= D	Review of Medical Condition of Resident - NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.0302) 1. If, after conducting an	0840	1) In depth training of the staff. Review of behavioral policy 2) The training will include understanding and the recognition of behavioral patterns of the residents and how to address them.	05/04/2022

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	inspection or investigation of a residential facility, the Bureau determines that it is necessary to review the medical condition of a resident, the Bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the Bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the Bureau, provide to the Bureau: (a) The assessments made by physicians concerning the physical and mental condition of the resident; and (b) Copies of prescriptions for medication or orders of physicians for services or equipment necessary to provide care for the resident. Inspector Comments: Based on observation, interview, and record review, the Bureau of Health Care Quality and Compliance (HCQC) determined a current review by a physician of the physical and mental condition of 1 of 6 sampled residents was necessary (Resident #1). Findings include: The facility is endorsed for elderly or disabled persons with chronic illness. The facility submitted an application for an Alzheimer's endorsement on 11/21/21, which is pending approval. Resident #1 (R1) R1 was admitted to the facility on 07/25/20 with diagnoses including dementia and depression. The Physician's Statement dated 09/08/21 documented R1 had cognitive impairment and unsafe ambulation. The Physician's Standard Placement Determination dated 10/15/21, documented R1 was appropriate to remain as a Residential Facility for Group resident in a non-Alzheimer's facility. The Physician's Standard Placement Determination dated 12/22/22, documented R1 had diagnoses including dementia, insomnia, depression, had an unsteady gait, was alert and oriented to self only, and was confused, and was appropriate for a Residential Facility for Groups which provided care to persons with Alzheimer's		3) Administrator will monitor 4) Administrator 5) 05/01/2022	

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	disease or related dementia. The Activities of Daily Living (ADL) Assessment dated 01/25/22 documented R1 was not oriented and was not able to follow instructions. Incident Reports documented R1 had combative behaviors toward Caregivers on 02/22/22 and 02/24/22, and hit another resident on the legs on 03/03/22. There was no documentation of a Physician's Statement and Standard Placement Determination following the aggressive incidents in February and March of 2022. On 03/24/22, R1 was alert to person (name), and was not able to indicate place or date. A mini cognitive assessment of R1 revealed R1 was unable to accurately answer where they were located, time of day or day of the week, the year, or who the President was. R1 appeared confused and did not recall the incident on 03/03/22 in which R1 left the room, went into another resident's room, and hit the resident on the legs. On 03/24/22, the Facility Manager and the Administrator acknowledged they were aware of R1's diagnosis of dementia and exit-seeking, wandering and aggressive behaviors. They confirmed R1 had a diagnosis of dementia and the facility did not have an Alzheimer's endorsement. Severity: 2 Scope: 1			