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 _____	**11/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE QUAIL HOUSE	**3695 E QUAIL AVE, LAS VEGAS, NEVADA ,89120**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey, infection control survey, and complaint investigation conducted at your facility on 11/10/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 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 Alzheimer's disease Category II residents. The census at the time of survey was eight. Eight resident files and six employee files were reviewed. The facility received a grade of D. One complaint was investigated: Complaint #NV00064979 with four allegations was substantiated: Allegation #1: The Administrator failed to report an allegation of Elder Abuse within 24 hours to Aging and Disability Services Adult Protective Services (APS) was substantiated. (See Tag #590) Allegation #2: Caregivers refused to assist a resident back inside the facility after a resident was left outside in the evening could not be substantiated based on interviews with the Administrator who denies the event occurred. Interviews with a resident and a resident's family member who explained the staff have always been helpful and willing to assist. Observations of the caregivers bringing coffee and water to the residents in their rooms and assisting residents to the table for breakfast. Observations of the caregivers responding to a call bell system when activated by the resident. Allegation #3: A caregiver bruised a resident's arm when they closed the refrigerator door on the resident's arm could not be substantiated based on interviews with the Administrator who explained the resident's bruise is a result of a fall the resident had in the kitchen when the resident fell against their wheelchair. A review of an incident	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: PATRICIA THERESA BRUSHFIELD | Title: Asst. to Administrator | Date: 12/17/2021

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	report which indicated the resident had fallen against their wheelchair causing a bruise. Interviews with a resident and a resident's family member who explained they feel the staff in the facility are respectful towards the residents and they have never witnessed or experienced any type of abuse. Allegation #4: Caregivers are rude when speaking to the residents could not be substantiated based on interviews with a resident and a resident's family member who explained the residents are always treated with dignity and respect by the facility staff. Interview with the Administrator who denies the staff are rude to the residents and explained all caregivers are required to speak with the residents with dignity and respect. Observations of the staff speaking with the residents with dignity and respect in the resident rooms, the hallways, the kitchen and the rear yard. The investigation into the allegation included: Observations of caregivers bringing water and coffee to the residents in their rooms. Observations of caregivers assisting residents to the table for breakfast. Observations of caregivers speaking to residents with dignity and respect in the hallways, the residents' rooms, the kitchen and the rear yard. Document review of all incident reports for the previous six months. Interviews with three residents, two residents' family members, and the Administrator. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of non-discrimination 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			

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	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:			
0590 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on interview, and documentation review, the facility failed to ensure an allegation of physical abuse by an employee was reported to the appropriate authorities for 1 of 8 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 12/23/20, with a diagnoses including Parkinson's Disease, dementia, coronary artery disease, hypothyroidism and hypertension. On 11/10/21 in the morning, R1 explained sometime in September they had reported a caregiver had closed a refrigerator door on their arm which caused bruising. R1 indicated they had told facility management about the incident and initially facility management had not done anything. R1 indicated it was not until they contacted the State of Nevada Ombudsman's office the management responded to their concerns about the caregiver. On 11/10/21 in the morning, a review of a report from the State of Nevada Ombudsman's Office revealed an Ombudsman had spoken to the Administrator about the allegations on 09/23/21. The Ombudsman advised the Administrator it was a requirement to report	0590	1. Complaint/grievance may be inwriting or verbal. The Administrator reported the incident to Aging Service who instructed her to contact Adult Protective Services and she thought that she had 3 business days to make the report. Adult Protective services explained to the caregivers that they need to report any complaint of abuse where are not substantiated within 24 hours of the	11/11/2021

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	allegations of abuse to the State of Nevada Adult Protective Services Unit (APS) within 24 hours. On 09/28/21 the Ombudsman asked if the Administrator had reported the allegation to APS and the Administrator reported they had not contacted APS. On 11/10/21 in the afternoon, the Administrator confirmed they had not reported the incident after the Ombudsman had advised the Administrator to do so on 09/23/21 and had not made a report to APS when the Ombudsman followed up on 09/28/21. Severity: 2 Scope: 1 Complaint #NV00064979		incident. a) Resident b) Family member c) Guardian d) Other concerned persons 1. Complaints or grievances should be reported to the. Administrator, or the House Manager 2. If a resident is not capable of making a written complaint, he/she can have the caregiver complete the complaint form for them, or they can make a verbal complaint to any of the above-named persons.	

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			3. The caregiver must see that all complaints or grievances (verbal or written) are reported immediately to one of the persons named. 4. The complaint will be investigated immediately if there is indication the resident is in jeopardy. If the complaint does not indicate the resident or anyone else is in jeopardy the complaint will be investigated within 48 hours. 5. After investigation and evaluation of the complaint, if it is found that action needs to be taken, Administrator, will	

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			exert all efforts to resolve the complaint to the satisfaction of the complainant with reasonable boundaries. 6. An in-service was held on November 11, 2021 to explain to the staff the procedures regarding complaints in the future. 7. Also, the standard of care dictates that a mandated reporter **may not wait for proof; they are not allowed to delay reporting. The mandatory reporter must report the incident with-in 24 hours to Adult Protective services. Dial 2-1-1 or 702-486-3545**	
0938 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that	0938	We will use are admission package that includes the plan of care. When we do a *care plan* for a specific resident we:	12/12/2021

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	is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and document review, the facility failed to ensure activities of daily living (ADL) were assessed upon admission for 3 of 8 residents (Residents #2, #3, and #8). On 11/10/21 in the morning, resident file reviews revealed the following: Resident #2 (R2) was admitted on 09/16/21 with diagnoses including dementia, and hypertension. The resident file lacked an initial ADL assessment upon admission. Resident #3 (R3) was admitted on 10/12/21 with diagnoses including Alzheimer's disease and angiopathy. The resident file lacked an initial ADL assessment upon admission. Resident #8 (R8) was admitted on 06/20/21 with diagnoses including diabetes mellititus and neuropathy. The resident file lacked an initial ADL assessment upon admission. On 11/10/21 in the morning, Employee #6 acknowledged R2, R3 and R8 did not have documented evidence of an initial ADL assessment upon admission. Severity: 2 Scope: 2		• Ascertain what the residents care and service needs are • We create a routine care schedule for staff to follow to assist the resident • We write pertinent information down on various types of documents so that everyone can understand the resident’s health problems and needs, how to meet those needs and what to watch in relation to his/her health problems so that if symptoms should arise, the resident’s physician can be notified • We address the resident’s concerns and devise a system of support for his or her wellbeing • We use a team approach, with the resident, family member or responsible parties involved • We assign duties to specific staff members • We review as often as needed so that we can adjust the plan according to the resident’s current care needs and the effectiveness of the plan	

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			We will use a move-in checklist to ensure that all information has been completed for each resident. The Administrator is the person responsible for the implantation of the correction.	
0994 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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp items and tools were secured from residents with Alzheimer's disease and/or dementia. Findings include: On 11/10/21 in the morning, a pair of scissors was observed unsecured in the bathroom of Resident #1. In the afternoon observed a fire poker with a sharp edge was unsecured next to the fireplace. On 11/10/21 in the afternoon, the Administrator acknowledged the scissors and the fire poker should have been secured and made inaccessible to residents. Severity: 2 Scope: 3	0994	1. The facility had an in-service to discuss the problems of leaving sharp objects out. 2. We plan to use a form for the House Manager to use daily to ensure that the physical property is safe for all residents. 3. We will require the House Manager to follow this policy and have them address it in their daily report. 4. The Administrator is the responsible party to implement the policy.	12/10/2021

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0999 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: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents. Findings include: On 11/10/21 in the morning, during a tour of the facility, a cabinet door under the sink in the kitchen was observed unlocked with a bag of unsecured laundry detergent pods stored on the bottom shelf. On 11/10/21 in the afternoon, the Administrator acknowledged the detergent should have been secured and stored inaccessible to residents. Severity: 2 Scope: 3	0999	1. The facility had an in-service to discuss the problems of leaving any and all chemicals or toxic items in reach of a resident. 2. We plan to use a form for the House Manager to use daily to ensure that the physical property is safe for all residents. 3. All items will be locked-up as soon as the chemical has been used, measured and poured immediately after use. 4. We will require the House Manager to follow this policy and have them address it in their daily report. 5. The Administrator is the responsible party to implement the policy.	12/12/2021

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1001 SS= F	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. Inspector Comments: Based on record review and interview, the facility failed to ensure 5 of 6 employees received four hours of initial training to care for elderly and disabled residents, within 60 days of hire (Employee #2, #3, #4, #5, and #6). Findings include: On 11/10/21 in the afternoon, a review of employee files revealed the following: Employee #2 (E2) E2 was hired as a Medication Technician on 05/28/21. E2's file lacked documented evidence of four hours of initial caregiver training within 60 days of hire. Employee #3 (E3) E3 was hired as a Medication Technician on 03/26/21. E3's file lacked documented evidence of four hours of initial caregiver training within 60 days of hire. Employee #4 (E4) E4 was hired as a Medication Technician on 03/23/21. E4's file lacked documented evidence of four hours of initial caregiver training within 60 days of hire. Employee #5 (E5) E5 was hired as a Medication Technician on 04/28/21. E5's file lacked documented evidence of four hours of initial caregiver training within 60 days of hire. Employee #6 (E6) E6 was hired as a Medication Technician on 08/23/21. E6's file lacked documented evidence of four hours of initial caregiver training within 60 days of hire. On 11/10/21 in the afternoon, the Administrator acknowledged E2, E3, E4, E5 and E6 did not receive elderly and disabled care giving training within 60 days after being employed. Severity: 2 Scope: 3	1001	NAC 449.196 (1) (F), Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. The facility has met the requirements of NAC449.2756 (1) (d) and NAC 449.2768. The House Manager and/or the Administrator will use the Employee checklist for training when we are hiring a new employee. The Administrator will check the files every December and June to ensure that the files are in order. For new employee the House Manager and/or Administrator will review the checklist to ensure that the newly hired caregiver has complied with all regulations as specified in Nevada Administrative Code. The Administrator is the person responsible for implementation of this deficiency.	12/10/2021
1011 SS= F	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which	1011	The facility has contracted with a outside agency to give the training on December 14,	12/17/2021

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	offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. Inspector Comments: Based on record review and interview, the facility failed to ensure eight hours of mental illness training was completed within 60 days of hire for 6 of 6 employees (Employee #1, #2, #3, #4, #5, and #6). Findings include: On 11/10/21 in the afternoon, a review of employee files revealed the following: Employee #1 (E1) E1 was hired as the Administrator on 02/25/21. E1's file lacked documented evidence of eight hours of mental illness training within 60 days of hire. Employee #2 (E2) E2 was hired as a Medication Technician on 05/28/21. E2's file lacked documented evidence of eight hours of mental illness training within 60 days of hire. Employee #3 (E3) E3 was hired as a Medication Technician on 03/26/21. E3's file lacked documented evidence of eight hours of mental illness training within 60 days of hire. Employee #4 (E4) E4 was hired as a Medication Technician on 03/23/21. E4's file lacked documented evidence of eight hours of mental illness training within 60 days of hire. Employee #5 (E5) E5 was hired as a Medication Technician on 04/28/21. E5's file lacked documented evidence of eight hours of mental illness training within 60 days of hire. Employee #6 (E6) E6 was hired as a Medication Technician on 08/23/21. E6's file lacked documented evidence of eight hours of mental illness training within 60 days of hire. On 11/10/21 in the afternoon, the Administrator acknowledged E1, E2, E3, E4, E5 and E6 did not receive eight hours of mental illness training within 60 days of hire. Severity: 2 Scope: 3		202. We will email the completed 8 hour certificates to the HCQC. Employees #3 and #4 no longer are employed by the facility. The House Manager and/or the Administrator will use the Employee checklist for training when we are hiring anew employee. The Administrator will check the files every December and June to ensure that the files are in order. For new employee the House Manager and/or Administrator will review the checklist to ensure that the newly hired caregiver has complied with all regulations as specified in Nevada Administrative Code. The Administrator is the person responsible for implementation of this deficiency.	

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1021 SS= F	Care for Persons with Chronic Illnesses - NAC 449.2766 Residential facility which offers or provides care for persons with chronic illnesses and debilitating diseases: Application for endorsement; training for employees. (NRS 449.0302) 2. Within 60 days after being employed by a residential facility for persons with chronic illnesses, an employee of the facility shall obtain at least 4 hours of in-service training relating to the care provided to such persons and in the actions necessary to control infections. 3. Evidence of training received pursuant to subsection 2 must be included in the employee ' s personnel file. Inspector Comments: Based on record review and interview, the facility failed to ensure four hours of chronic illness training was completed for 6 of 6 employees (Employee #1, #2, #3, #4, #5 and #6). Findings include: On 11/10/21 in the afternoon, a review of employee files revealed the following: Employee #1 (E1) E1 was hired as the Administrator on 02/25/21. E1's file lacked documented evidence of four hours of chronic illness training within 60 days of hire. Employee #2 (E2) E2 was hired as a Medication Technician on 05/28/21. E2's file lacked documented evidence of four hours of chronic illness training within 60 days of hire. Employee #3 (E3) E3 was hired as a Medication Technician on 03/26/21. E3's file lacked documented evidence of four hours of chronic illness training within 60 days of hire. Employee #4 (E4) E4 was hired as a Medication Technician on 03/23/21. E4's file lacked documented evidence of four hours of chronic illness training within 60 days of hire. Employee #5 (E5) E5 was hired as a Medication Technician on 04/28/21. E5's file lacked documented evidence of four hours of chronic illness training within 60 days of hire. Employee #6 (E6) E6 was hired as a Medication Technician on 08/23/21. E6's file lacked documented evidence of four hours of chronic illness training within 60 days of	1021	Some employees have completed the training. Some still have one hour of training to complete E #2,4 and 5 will do a self study on Diabetes The House Manager and/or the Administrator will use the Employee checklist for training when we are hiring anew employee. The Administrator will check the files every December and June to ensure that the files are in order. For new employee the House Manager and/or Administrator will review the checklist to ensure that the newly hired caregiver has complied with all regulations as specified in Nevada Administrative Code. The Administrator is the person responsible for implementation of this deficiency.	12/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**11/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE QUAIL HOUSE	**3695 E QUAIL AVE, LAS VEGAS, NEVADA ,89120**

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	hire. On 11/10/21 in the afternoon, the Administrator acknowledged E1, E2, E3, E4, E5 and E6 did not receive four hours of chronic illness training within 60 days of hire. Severity: 2 Scope: 3			
1036 SS= F	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease. Inspector Comments: Based on record review and interview, the facility failed to ensure 5 of 6 employees completed the required eight hours of dementia training within three months of hire (Employee #2, #3, #4, #5, and #6) Findings include: On 11/10/21 in the afternoon, a review of employee files revealed the following: Employee #2 (E2) E2 was hired as a Medication Technician on 05/28/21. E2's file lacked documented evidence of eight hours of dementia training within three months of the date of hire. Employee #3 (E3) E3 was hired as a Medication Technician on 03/26/21. E3's file lacked documented evidence of eight hours of dementia training within three months of the date of hire. Employee #4 (E4) E4 was hired as a Medication Technician on 03/23/21. E4's file lacked documented evidence of eight hours of	1036	NAC 449.196 (1) (F), Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. The facility has met the requirements of NAC449.2756 (1) (d) and NAC 449.2768. The House Manager and/or the Administrator will use the Employee checklist for training when we are hiring anew employee. The Administrator will check the files every December and June using the Personnel Checklist to ensure that the files are in order. For new employee the House Manager and/or Administrator will review the "employee checklist" to ensure that the newly hired caregiver has complied with all regulations as specified in Nevada Administrative Code. The Administrator is the person responsible for implementation of this deficiency.	12/10/2021

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 _____	**11/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE QUAIL HOUSE	**3695 E QUAIL AVE, LAS VEGAS, NEVADA ,89120**

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	the date of hire. Employee #5 (E5) E5 was hired as a Medication Technician on 04/28/21. E5's file lacked documented evidence of eight hours of dementia training within three months of the date of hire. Employee #6 (E6) E6 was hired as a Medication Technician on 08/23/21. E6's file lacked documented evidence of eight hours of dementia training within three months of the date of hire. On 11/10/21 in the afternoon, the Administrator acknowledged E2, E3, E4, E5 and E6 did not receive eight hours of dementia training within three months of the date of hire. Severity: 2 Scope: 3			