

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3228AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/23/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>DIGNIFIED CARE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2915 EL CAMINO RD LAS VEGAS, NV 89146</b>		
(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) COMPLETE DATE
Y 000	Initial Comments  This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on October 23, 2008.  The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.  The facility was licensed for 10 total beds.  The facility had 10 Category 2 beds.  The facility had the following endorsements: Residential facility which provides care to persons with Alzheimer's disease  The census at the time of the survey was 10. 10 resident files were reviewed and 3 employee files were reviewed.  The findings and conclusions of any investigation by the Health Division 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:	Y 000		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check  NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to	Y 105		

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

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 105	Continued From page 1 449.185, inclusive.  This Regulation is not met as evidenced by: Based on personnel file review, the facility failed to ensure 1 of 3 employees (#1) was re-fingerprinted after the original prints were expired.  Findings include:  The file for Employee #1, admitted 12/1/02, revealed an old copy of the employee's fingerprints dated 11/5/02 with evidence of State clearance on 4/14/03. However, it is required to obtain new fingerprints and State clearance every 5 years.  Severity: 2 Scope: 3	Y 105		

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