

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 12/17/08.  The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.  The facility was licensed for 9 total beds.  The facility had the following category of classified beds: Category 2- 9 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 7. Seven resident files were reviewed and 7 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 103 SS=F	449.200(1)(d) Personnel File - NAC 441A  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:	Y 103		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 103	Continued From page 1  (d) The health certificates required pursuant to chapter 441A of NAC for the employee.  This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. (NRS 441A.120) 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and	Y 103		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 103	Continued From page 2  any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. É If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200 . 7. A medical facility shall maintain surveillance of employees for the development of pulmonary	Y 103		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 103	Continued From page 3  symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A by R084-06, 7-14-2006)  Based on interview and record review the facility failed to ensure 1 of 7 employees had the required tuberculosis (TB) screening test documentation (Employee #1).  Findings include:  Employee #1 was hired in 1992. The employee file lacked documented evidence of an annual TB symptom surveillance form for 2008.  The employee indicated the signs and symptoms checklist was in her other facility. The employee revealed she was aware the checklist was required.  Severity: 2                  Scope: 3	Y 103		
Y 104 SS=B	449.200(1)(e) Personnel File - References  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: (e) Evidence that the references supplied by the employee were checked by the residential facility.	Y 104		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 104	Continued From page 4  This Regulation is not met as evidenced by: Based on record review, the facility failed to investigate the references for 2 of 7 employees (Employee #6 and #7).  Employee #6 was hired on 9/5/05. There was no documented evidence of investigation of references in the employee file.  Employee #7 was hired on 9/30/07. There was no documented evidence of investigation of references in the employee file.  Severity: 1            Scope: 2	Y 104		
Y 105 SS=D	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 449.185, inclusive.  This Regulation is not met as evidenced by: NRS 449.179 Initial and periodic investigations of criminal history of employee or independent contractor of certain agency or facility. 1. Except as otherwise provided in subsection 2, within 10 days after hiring an employee or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility	Y 105		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 105	Continued From page 5  for intermediate care, a facility for skilled nursing or a residential facility for groups shall: (a) Obtain a written statement from the employee or independent contractor stating whether he has been convicted of any crime listed in NRS 449.188 (b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a); (c) Obtain from the employee or independent contractor two sets of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (d) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (c). 2. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups is not required to obtain the information described in subsection 1 from an employee or independent contractor who provides proof that an investigation of his criminal history has been conducted by the Central Repository for Nevada Records of Criminal History within the immediately preceding 6 months and the investigation did not indicate that the employee or independent contractor had been convicted of any crime set forth in NRS 449.188. 3. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall ensure that the	Y 105		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 105	Continued From page 6  criminal history of each employee or independent contractor who works at the agency or facility is investigated at least once every 5 years. The administrator or person shall: (a) If the agency or facility does not have the fingerprints of the employee or independent contractor on file, obtain two sets of fingerprints from the employee or independent contractor; (b) Obtain written authorization from the employee or independent contractor to forward the fingerprints on file or obtained pursuant to paragraph (a) to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (c) Submit the fingerprints to the Central Repository for Nevada Records of Criminal History.  Based on record review, the facility failed to ensure 1 of 7 employees had copies of fingerprints in the file (Employee #5).  Findings include:  Employee #5 was hired on 4/10/96. The file lacked documented evidence of two copies of the employee's fingerprints.  Severity: 2            Scope: 1	Y 105		
Y 870 SS=E	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration  NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or	Y 870		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 870	<p>Continued From page 7</p> <p>registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident.</p> <p>This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 3 of 7 residents residing in the facility for longer than six months (Resident #1, #4 and #6).</p> <p>Findings include:</p> <p>Resident #1 was admitted on 11/15/07. The only medication profile review available in the record was dated 2/6/08.</p> <p>Resident #4 was admitted on 6/26/05. There was no medication profile review in the record prior to 5/27/08. The resident was admitted to Hospice services 7/28/08. The Hospice nurse reviews the medications monthly.</p> <p>Resident #6 was admitted on 11/5/06. There was documented evidence of a medication review for 2/15/07 and 6/9/08.</p> <p>Employee #1 was hired in 1992. The employee indicated the residents are not scheduled to see the physician every six months, so the facility</p>	Y 870		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 870	Continued From page 8  does not do the medication review. The employee indicated she was not aware the medication review was required every six months.  Severity: 2                      Scope: 2	Y 870		
Y 876 SS=B	449.2742(4) NRS 449.037  NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met.  This Regulation is not met as evidenced by: NRS 449.037(6). The Board shall adopt separate regulations regarding the assistance which may be given pursuant to NRS 453.375 <NRS and 454.213to an ultimate user of controlled substances or dangerous drugs by employees of residential facilities for groups. NRS 453.375 Authority to possess and administer controlled substances. A controlled substance may be possessed and administered by the following persons: 6. An ultimate user or any person whom the ultimate user designates pursuant to a written agreement. NRS 454.213 Authority to possess and administer dangerous drug. A drug or medicine referred to in NRS 454.181 to 454.371, inclusive, may be possessed and administered by: 10. An ultimate user or any person designated by the ultimate user pursuant to a written agreement.	Y 876		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 876	Continued From page 9  Based on record review, the facility failed to ensure that an ultimate user agreement was signed for 2 of 7 residents (Resident #1 and #7).  Findings include:  Resident #1 was admitted on 11/15/07. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Resident #7 was admitted on 4/1/08. The resident's file did not contain a signed ultimate user agreement that authorized the facility to administer medications to the resident.  Severity: 1                      Scope: 2	Y 876		
Y 877 SS=D	449.2742(5) OTC medications & Dietary Supplements  NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medication and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744.	Y 877		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 877	Continued From page 10  This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to obtain physician orders to administer over-the-counter (OTC) medications for 1 of 7 residents (Resident #7).  Resident #7 was admitted on 4/1/08 with diagnoses including Dementia, Hypertension, Osteoporosis and Alzheimer ' s Disease. Aspirin 81 milligrams (mg) was found in the medication bag. Aspirin 81 mg 1 tablet daily was written on the Medication Administration Record (MAR). There was no documented evidence of a physician order in the resident's record.  Employee #3 revealed the resident's sister brought the Aspirin and requested the facility administer 1 tablet every day to the resident. The employee indicated she was not aware a physician's order was required.  Severity: 2                      Scope: 1	Y 877		
Y 911 SS=D	449.2746(2)(d) PRN Medication Record  NAC 449.2746 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (d) The results of the administration of the medication.  This Regulation is not met as evidenced by: Based on interview and record review, the facility	Y 911		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 911	<p>Continued From page 11</p> <p>failed to document results of the administration of as needed medication for 1 of 7 residents (Resident #7).</p> <p>Findings include:</p> <p>Resident #7 was admitted on 4/1/08 with diagnoses including Dementia, Hypertension, Osteoporosis and Alzheimer's Disease. Lorazepam 0.5 milligrams (mg) 1 tablet at bedtime as needed (PRN) for anxiety. Lorazepam was documented on the Medication Administration Record (MAR) instead of the PRN record for the months of July 2008, August 2008, September 2008, October 2008, November 2008 and December 2008. There was no documented evidence of the results of the medication administration.</p> <p>Employee #1 indicated the resident would scream and wander at night if the medication was not given to the resident. The employee indicated she did not realize the MAR should include PRN when the resident was receiving the medication every night.</p> <p>Resident #7 was receiving Temazepam 15 mg 1 tablet at bedtime PRN. Temazepam was documented on the Medication Administration Record (MAR) instead of the PRN record for the months of July 2008, August 2008, September 2008, October 2008, November 2008 and December 2008. There was no documented evidence of the results of the medication administration.</p> <p>Employee #3 indicated the physician was aware the medication was given every night and approved the administration. There was no documented order indicating the medication</p>	Y 911		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 911	Continued From page 12  could be given every night. The employee revealed she did not know she needed an order from the physician.  Severity: 2                      Scope: 1	Y 911		
Y 920 SS=F	449.2748(1) Medication Storage  NAC 449.2748 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. Medication 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 without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.  This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure medication was kept in a locked container for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7).	Y 920		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 920	Continued From page 13  Findings include:  On 12/17/08 at 9:20 AM, medications were observed in plastic medication cups inside of a plastic container placed in an unlocked drawer in the kitchen. Each plastic medication cup had the last name of the resident and the time the medication was to be given.  Employee #3 was hired on 9/10/07. The employee indicated she sets up the medications for the day. The employee could easily give the medication after the resident finished their breakfast. The employee revealed after the morning medications were given, the container was placed in the locked cabinet with all the other medications until the next medication pass.  Severity: 2                      Scope: 3	Y 920		
Y 922 SS=D	449.2748(3)(a) Medication Labeling  NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician.  This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure medications were plainly labeled for 1 of 7 residents (Resident #1).	Y 922		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 922	Continued From page 14  Findings include:  Resident #1 was admitted on 11/15/07. A bottle of Aspirin was located in the resident's medication basket was not labeled with the resident's name or the name of the prescribing physician.  Employee #3 revealed she was not aware the bottle needed to be labeled with the name of the resident and the physician.  Resident #1 had a container of Furosemide. The original label indicated the prescription was written in the name of the resident's daughter. Furosemide 40 milligrams give 1 daily was on the label. The 40 milligrams was crossed off and 20 milligrams placed on the container. The resident's name was also added to the label. The physician's order for the resident was for Furosemide 20 milligrams, give 1 daily.  Employee #3 indicated the daughter had given the Furosemide ordered for herself to her mother (Resident #1) due to the daughter was not able to afford to buy the medication for her mother. The employee revealed she cut the tablets in half to provide 20 milligrams to the patient.  Severity: 2                      Scope: 1	Y 922		
Y 936 SS=F	449.2749(1)(e) Resident file  NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all	Y 936		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 936	Continued From page 15  records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.  This Regulation is not met as evidenced by: NAC 441A.380 is hereby amended to read as follows: 441A.380 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing, or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing, or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu, or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If	Y 936		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 936	Continued From page 16  there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner.  (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.  3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis.  4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and	Y 936		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 936	Continued From page 17  Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis.  5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home, or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days.  6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200.  7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive	Y 936		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 936	<p>Continued From page 18</p> <p>tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person's medical record.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 7 residents complied with NAC 441A.380 regarding tuberculosis screening tests (Resident #1 and #3).</p> <p>Findings include:</p> <p>Resident #1 was admitted on 11/15/07. The file contained documentation the resident completed the required two-step TB skin testing on 11/16/07. The file did not contain proof the resident received an annual one-step TB skin test for 2008.</p> <p>Resident #3 was admitted on 3/31/05. The file contained documentation the resident completed the required two-step TB skin testing on 7/27/04. The file contained evidence the resident completed an annual one-step TB skin test on 7/22/05 and 6/3/06. The file contained evidence the resident had a negative chest x-ray 7/12/07. The file did not contain evidence the resident received an annual one-step TB skin test for 2007 or 2008.</p> <p>Employee #1 indicated the facility had a very difficult time getting the TB skin test when the resident was on Hospice services.</p> <p>Severity: 2                      Scope: 3</p>	Y 936		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 941	Continued From page 19	Y 941		
Y 941 SS=B	<p>449.2749(1)(h) Resident file</p> <p>NAC 449.2749</p> <p>1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that 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:</p> <p>(h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident.</p> <p>This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to have the rules of the facility signed by the administrator of the facility and/or the resident for 2 of 7 residents (Resident #1, and #7).</p> <p>Resident #1 was admitted on 11/15/07. Review of the records failed to provide documented evidence the rules of the facility were signed by the administrator of the facility and the resident.</p> <p>Resident #7 was admitted on 4/1/08 . Review of the records failed to provide documented evidence the rules of the facility were signed by the administrator of the facility and the resident.</p> <p>Employee #1 indicated she was not sure why the</p>	Y 941		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3671AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALZHEIMERS LUXURY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2951 VIKING ROAD LAS VEGAS, NV 89121</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 941	Continued From page 20 rules were not signed.  Severity: 1    Scope: 2	Y 941		

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