

Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS1932AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/25/2009 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER C N C ALZHEIMER'S HOME CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 7765 CLEARWOOD AVE LAS VEGAS, NV 89123 | | |
| (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 | <p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 2/25/09.</p> <p>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.</p> <p>The facility is licensed for 9 total beds, classified as Category 2 beds.</p> <p>The facility has the following endorsement: Residential facility which provides care to persons with Alzheimer's disease</p> <p>The census at the time of the survey was 5. 6 sample resident files were reviewed, 1 discharged resident file and 4 employee files were reviewed.</p> <p>The following complaints were reviewed: NV00019815 - Unsubstantiated</p> <p>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.</p> <p>The following regulatory deficiencies were identified at the time of the survey.</p> | Y 000 | | |
| Y 072 SS=D | <p>449.196(3) Qualications of Caregiver-Med re-training</p> <p>NAC 449.196</p> <p>3. If a caregiver assists a resident of a residential</p> | Y 072 | | |

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: NVS1932AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/25/2009 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER C N C ALZHEIMER'S HOME CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 7765 CLEARWOOD AVE LAS VEGAS, NV 89123 | | |
| (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 072 | Continued From page 1 facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 2/25/09, the facility failed to ensure that 1 of 4 caregivers had completed the required three hour medication management refresher training every three years (Employee #3). Severity: 2 Scope: 1 | Y 072 | | |
| Y 274 SS=C | 449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal. | Y 274 | | |

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: NVS1932AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/25/2009 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER C N C ALZHEIMER'S HOME CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 7765 CLEARWOOD AVE LAS VEGAS, NV 89123 | | |
| (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 274 | Continued From page 2 | Y 274 | | |
| Y 859 SS=D | <p>This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure menu substitutions were documented and retained for at least 90 days.</p> <p>Severity: 1 Scope: 3</p> <p>449.274(5) Periodic Physical examination of a resident</p> <p>NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.</p> <p>This Regulation is not met as evidenced by: Based on record review on 2/25/09, the facility failed to ensure that 1 of 7 residents received an initial physical prior to admission to the facility (Resident #6).</p> <p>Severity: 2 Scope: 1</p> | Y 859 | | |
| Y 999 SS=F | 449.2754(1)(g) Alzheimer's Facility | Y 999 | | |

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: NVS1932AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/25/2009 |
| NAME OF PROVIDER OR SUPPLIER C N C ALZHEIMER'S HOME CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 7765 CLEARWOOD AVE LAS VEGAS, NV 89123 | | |
| (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 999 | Continued From page 3 NAC 449.2756 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. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure all toxic substances were not accessible to the residents of the facility. Severity: 2 Scope: 3 | Y 999 | | |

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