

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	<p><i>Acceptable POC 3/13/09</i> <i>J. Seeger</i></p> <p>Y072 Qualifications of Caregiver Medication Re-training</p> <ol style="list-style-type: none"> The administrator of the facility shall ensure that the caregiver has received training in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must. The caregiver has receive, at least 3 hours of training in the management of medication and pass an examination relating to the management of medication approved by the Bureau, at least every 3 years. The administrator has decided not to allow Employee #3 to pass medications to the residents. The administrator shall ensure that there is always someone trained to pass medications at the home, who has passed an approved examination as stated above. The administrator is the person responsible to ensure that only a trained person passes medication at the home. 	
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.

Eugenia B. Cabreza
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

6899

ORO711

TITLE

Administration

(X6) DATE

3/3/09

RECEIVED If continuation sheet 1 of 4

MAR 03 2009

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	5. The deficiency was corrected on February 25, 2009 the day of the survey. Y 274 NAC 449.2175 Service of food-substitution 1. It is the responsibility of the administrator to ensure that menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. 2. 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 serving of the meal. 3. The administrator had an in-service and explained to all employees that they must document all food substitutions as stated on number two (2) above. (Attachment "1" copy of in-service) 4. The administrator is the person responsible to ensure that all employees understand the regulations.	
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.

STATE FORM

6899

ORO711

RECEIVED

If continuation sheet 2 of 4

MAR 03 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

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 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. Severity: 1 Scope: 3	Y 274	5. The deficiency was corrected on February 28, 2009 the day of the survey.	
Y 859 SS=D	449.274(5) Periodic Physical examination of a resident 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. 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). Severity: 2 Scope: 1	Y 859	Y859 Periodic Physical examinations of a resident. 1. The Administrator has change the facility policy to ensure that a potential resident 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. 2. The Administrator had an in-service with staff and owners of the facility to address the fact that all potential residents must have a physical before admission to the facility (home). Attachment "1" copy of in-service) 3. The administrator is the person responsible to ensure that any	
Y 999 SS=F	449.2754(1)(g) Alzheimer's Facility NAC 449.2756	Y 999		

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

RECEIVED

MAR 03 2009

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	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>Severity: 2 Scope: 3</p>	Y 999	<p>new resident has their physical before entering the facility (home)</p> <p>4. The deficiency was corrected on February 28, 2009 the day of the survey.</p> <p>Y999 Alzheimer's Facility</p> <ol style="list-style-type: none"> 1. It is the responsible of the Administrator to ensure that all toxic substances are not accessible to the residents of the facility. 2. The Administrator had an in-service to go over items that should be locked away out of the reach of all residents and how a simple item that they may take for granted could be a deadly substance for a frail elderly person. (Attachment "1" copy of in-service) 3. The administrator is the person responsible to ensure that the employees understand the rules and regulation and train them appropriately. 4. The deficiency was corrected on February 28, 2009 the day of the survey. 	
-------	--	-------	---	--

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

RECEIVED

MAR 03 2009