

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2705AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2009
NAME OF PROVIDER OR SUPPLIER CHARLESTON RIDGE SENIORS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5313 PADUA WAY LAS VEGAS, NV 89107		
(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 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. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/26/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 5 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 5. Five resident files were reviewed and 4 employee files were reviewed. The following deficiencies were identified:	Y 000	<p><i>Acceptable POC 4/17/09 Slegnick</i></p> <p>RECEIVED APR 15 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p>	
Y 936 SS=E	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 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.	Y 936		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Francesca G. Embredo Admin* TITLE *Admin* (X6) DATE *4-15-09*

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Y 936	Continued From page 1 This Regulation is not met as evidenced by: Based on record review on 3/26/09, the facility failed to ensure 1 of 5 residents complied with NAC 441A.380 regarding tuberculosis (Resident #4) which affected all residents. This was a repeat deficiency from the 6/6/08 State Licensure survey. Severity: 2 Scope: 1	Y 936 Y036	a) Resident #4 has completed a two step tuberculin test on 4/1/09. (See Attachment # TAG Y036). b) All residents files will be reviewed a every 6 months to ensure that residents have current TB test. Resident file checklist will be ytilized to determine if TB test is needed. Residents will have to go for a TB test before the expiration date. The administrator will monitor for compliance. (Attachment # TAG Y936A). c) 04/01/09	<i>SS</i> 4/17/09

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LAS VEGAS, NEVADA

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