

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2311AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2009
NAME OF PROVIDER OR SUPPLIER A R C H OF LAS VEGAS		STREET ADDRESS, CITY, STATE, ZIP CODE 9483 LIGHTNING BAY CT 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	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 3/31/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 6 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 6. Six resident files were reviewed and 5 employee files were reviewed.	Y 000	<i>Acceptable POC Deegard 4/14/09</i>	
Y 103 SS=D	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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This RULE: is not met as evidenced by: Based on record review on 3/31/09, the facility failed to ensure 1 of 5 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #5) for the protection of 6 of 6 residents (Resident #1, #2, #3, #4, #5 and #6).	Y 103	<i>Y 103 Employee #5 got his 1st step PPD on RFA and scheduled to return on 4/8/09 for reading. Employee #5 with negative reading on 4/10/09.</i>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Deegard

TITLE *Director*

(X6) DATE

4/13/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2311AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2009
NAME OF PROVIDER OR SUPPLIER A R C H OF LAS VEGAS		STREET ADDRESS, CITY, STATE, ZIP CODE 9483 LIGHTNING BAY CT 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 103	Continued From Page 1 Severity: 2 Scope: 1	Y 103		
Y 859 SS=F	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 RULE: is not met as evidenced by: Based on record review on 3/31/09, the facility failed to ensure 4 of 6 residents received an annual physical (Resident #1, #4, #5 and #6). Severity: 2 Scope: 3	Y 859	Y859 . Resident # 1 is scheduled for annual physical exam with Dr. on 4/22/09. Resident #4 went to see Dr. on 4/17/09. per refer to attached H + P. Resident # 5 is scheduled for annual physical exam on 4/29/09 with Dr. Resident # 6 is scheduled for annual exam with Dr. on 4/24/09.	
Y 870 SS=F	449.2742(1)(a)(1)(2)(b)(c) 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 registered nurse who does not have a financial interest in the facility:	Y 870		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2311AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2009
NAME OF PROVIDER OR SUPPLIER A R C H OF LAS VEGAS		STREET ADDRESS, CITY, STATE, ZIP CODE 9483 LIGHTNING BAY CT 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 870	Continued From Page 2 (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. (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). This RULE: is not met as evidenced by: Based on record review and interview on 3/31/09, 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 4 of 4 residents residing at the facility for longer than six months (Resident #1, #3, #4 and #5). Severity: 2 Scope: 3	Y 870	<i>Y870 Resident #3, #4 & #5 have had a pharmacy review on 3/31/09, pls refer to attached documents. Resident #1 is scheduled to see Dr. on 4/22/09 for medication review.</i>	
Y 878 SS=E	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this	Y 878		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2311AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2009
NAME OF PROVIDER OR SUPPLIER A R C H OF LAS VEGAS		STREET ADDRESS, CITY, STATE, ZIP CODE 9483 LIGHTNING BAY CT 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 878	Continued From Page 3 subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This RULE: is not met as evidenced by: Based on record review and interview on 3/31/09, the facility failed to ensure 3 of 6 residents received medications as prescribed (Resident #1, #3 and #4). Severity: 2 Scope: 2	Y 878	Pls refer to attached corrected MAR for Resident #1 Medication rewritten: DetroL LA 4mg, take 2 capsules by mouth everyday. pls refer to attached MARKS. Resident #3, refer to attached corrected MAR medication rewritten: Lismopril 5mg by mouth twice a day pls refer to attached MAR Resident #4, pls refer to attached corrected MAR medication rewritten: furosemide 20mg (take 1 tablet by mouth every other day.	
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. This RULE: is not met as evidenced by: Based on record review and interview on	Y 936		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2311AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2009
NAME OF PROVIDER OR SUPPLIER A R C H OF LAS VEGAS		STREET ADDRESS, CITY, STATE, ZIP CODE 9483 LIGHTNING BAY CT 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 936	Continued From Page 4 3/31/09, the facility failed to ensure 3 of 6 residents complied with NAC 441A.380 regarding tuberculosis (Resident #1, #4 and #5) which affected all residents. Severity: 2 Scope: 2	Y 936	Resident #1 is scheduled for PPD on 4/22/09. Resident #1 was admitted in 2006 & did have 2 step montoux done in 9/2006. Resident has since refused follow up PPD for 2007 & 2008. Resident #4 received PPD on 04/7/09. Resident #5 received PPD on 3/24/09 which was read on 3/30/09 with negative results. pls. refer to attached documents.	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.