

Bureau of Health Care Quality and Compliance

| 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 03/29/2010 |
|---|---|---|---|---|
| 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 3/29/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six 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 four employee files were reviewed. The facility received a grade of A. | Y 000 | | |
| Y 106 SS=E | 449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Based on interview and record review on 3/29/10, | Y 106 | | |

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

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| Y 106 | Continued From page 1 the facility failed to ensure that 1 of 4 caregivers (Employee #1) had completed training in first aid and cardiopulmonary resuscitation (CPR). Severity: 2 Scope: 2 | Y 106 | | |
| Y 353 SS=B | 449.222(3) Bathrooms and Toilet Facilities NAC 449.222 3. The bottoms of tubs and showers must have surfaces that inhibit falling and slipping. Cabinets that are attached to the floor or grab bars must be adjacent to the tubs, toilets and showers. This Regulation is not met as evidenced by: Based on observation on 3/29/10, the facility did not ensure that 1 of 2 bathroom showers had a grab bar. Bath #1, Master bath does not have a safety grab bar. Severity: 1 Scope : 1 | Y 353 | | |

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