

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS108AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2011
NAME OF PROVIDER OR SUPPLIER CHARLESTON RESIDENTIAL CARE HOTEL		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 W CHARLESTON BLVD LAS VEGAS, NV 89102		
(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 a complaint investigation conducted in your facility from 6/28/11 through 8/8/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for one hundred twenty nine (129) Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the investigation was 111. Complaint #NV00028734 was substantiated. See TAG Y 681.	Y 000		
Y 681 SS=G	449.271(2) Prohibited Condition / Staph or Serious Infec NAC 449.271 Except as otherwise provided in NAC 449.2736, a person must not be admitted to a residential facility or permitted to remain as a resident of a residential facility if he: 2. Suffers from a staphylococcus infection or other serious infection. This Regulation is not met as evidenced by: Complaint # NV00028734 Based on record review and interview from	Y 681		

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 681	Continued From page 1 6/28/11 through 8/8/11, the facility allowed 1 of 111 residents to be re-admitted with an active case of Methicillin resistant staphylococcus aureus (MRSA) (Resident #1). Findings include: Resident #1 was an 84 year old female admitted to the facility on 1/13/95 with a diagnosis of chronic obstructive pulmonary disease (COPD). The resident lived in a shared room, shared the bathroom with a roommate and ate all meals in a common dining room. Resident #1 was sent to a local hospital on 6/19/11 on the advice of a home health agency for a wound culture test. The wound test came back positive for Methicillin resistant staphylococcus aureus (MRSA). The resident was placed on two antibiotics, Bactrim DS and Keflex. The resident was discharged from the hospital and readmitted to the facility on 6/20/11. According to a note written by the resident's physician assistant on 6/20/11, "the patient is currently being treated for MRSA to leg wound by myself and home health. Patient was put on Bactrim DS for infection...". The facility provided evidence it conducted an infection control in-service for its staff on 6/20/11. According to a note by the physician for Resident #1, the left leg was healed and all antibiotics were completed; wound was totally healed as of 6/28/11. The facility failed to ensure a resident undergoing treatment for MRSA was not admitted to the facility. Severity: 3 Scope: 1	Y 681		

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