

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS75AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>08/24/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BERNADETTE CARE HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1104 IRONWOOD DRIVE LAS VEGAS, NV 89108</b>		
(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 follow-up survey conducted in your facility from 8/23/11 through 8/24/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility was licensed for nine Residential Facility Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was nine.  The following deficiencies were identified:	Y 000		
Y 053 SS=H	449.194(4) Administrator's Responsibilities-Complete Rec  NAC 449.194 The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate.  This Regulation is not met as evidenced by: Based on a record review, observations and interviews from 8/23/11 through 8/24/11, it was determined the Administrator submitted an inaccurate Plan of Correction (POC) and failed to ensure the records of the facility were complete	Y 053		

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

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NV575AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>08/24/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>BERNADETTE CARE HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1104 IRONWOOD DRIVE LAS VEGAS, NV 89108</b>		
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Y 053	<p>Continued From page 1</p> <p>and accurate for 1 of 4 employee files (Employee #3-reference Tag 105).</p> <p>Findings include:</p> <p>During an annual State licensure survey on 8/3/11, it was determined the file for Employee #3 was missing fingerprints, and State and FBI background checks. The facility was cited under NAC 449.200 (1) (f) Personnel File-Background Check (TAG Y105), for failure to have a background check completed for Employee #3. The facility administrator and lead caregiver were informed during the survey that the background checks were necessary for Employee #3's continued employment.</p> <p>The facility administrator submitted a Plan of Correction (POC) on 8/19/11. The administrator noted the corrective action for the citation at TAG Y105 was that Employee #3 resigned. Employee #3's signed and dated resignation letter was included with the POC.</p> <p>During a follow-up visit on 8/23/11, Employee #3 was briefly observed in the facility. On a return visit to the facility on 8/24/11, Employee #3 was again observed in the facility. A review of the facility's staffing schedule showed Employee #3 was listed on the staff schedule and scheduled to work ten shifts from 8/16/11 through 8/31/11.</p> <p>The lead caregiver denied Employee #3 was still working in the facility and reported she had forgotten to take the employee off the staff schedule. The facility administrator was asked about Employee #3 being present in the facility and the administrator reported the employee was at the facility only to pick up his personal items. After further interview and document review, the</p>	Y 053		

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Y 053	Continued From page 2  lead caregiver and the facility administrator admitted Employee #3 continued to be employed at the facility.  A follow-up visit to the facility determined the Administrator provided inaccurate information on the POC for the 8/3/11 survey and continued to employ Employee #3 at the facility from 8/3/11 to 8/24/11 without the necessary background checks being conducted.  Severity: 3      Scope: 2	Y 053		
Y 105 SS=E	449.200(1)(f) Personnel File - Background Check  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: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.  This Regulation is not met as evidenced by: Based on record review, observations and interviews from 8/23/11 through 8/24/11, the facility failed to ensure 1 of 4 employees met background check requirements of NRS 449.176 to 449.188 (Employee #3 did not have fingerprints, State and FBI background checks).  This is a repeat deficiency from the 8/3/11 annual State licensure survey.  Severity: 2      Scope: 2	Y 105		

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