

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS109AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2011
NAME OF PROVIDER OR SUPPLIER CHERUBS RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2624 VALPARAISO STREET LAS VEGAS, NV 89108		
(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 onsite validation survey on 9/13/11 of your attestation questionnaire the facility submitted on 4/28/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The following deficiencies were identified:	Y 000		
Y 859 SS=D	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 Regulation is not met as evidenced by: Based on record review on 9/13/11, the facility failed to ensure 1 of 6 residents received a physical prior to admission (Resident #5).	Y 859		

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: NVS109AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2011
NAME OF PROVIDER OR SUPPLIER CHERUBS RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2624 VALPARAISO STREET LAS VEGAS, NV 89108		
(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 859	Continued From page 1 Severity: 2 Scope: 1	Y 859		
Y 876 SS=E	449.2742(4) Medication Administration NRS 449.037 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. This Regulation is not met as evidenced by: Based on record review on 9/13/11, the facility failed to comply with subsection 6 of NRS 449.037 as 2 of 6 residents medications were not at a maintenance level and required a medical assessment before administering (Resident #2 - Acetaminophen 325 milligrams (mg) take 1 tablet by mouth every 6 hours as needed for temperature greater than 102, Resident #3 - Q-PAP 325 mg take 2 tablets by mouth every 4 hours as needed for temperature greater than 100, and Acephen 650 mg suppositories unwrap and insert 1 suppository per rectum every 4 hours as needed for temperature greater than 100). Severity: 2 Scope: 2	Y 876		
Y 895 SS=B	449.2744(1)(b)(1) Medication / MAR	Y 895		

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

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS109AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2011
NAME OF PROVIDER OR SUPPLIER CHERUBS RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2624 VALPARAISO STREET LAS VEGAS, NV 89108		
(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 3 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 Regulation is not met as evidenced by: Based on record review on 9/13/11, the facility failed to ensure 1 of 6 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #6 2nd step not read). Severity: 2 Scope: 1	Y 936		

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