

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and infection control State Licensure survey conducted at your facility on 06/27/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 beds for the elderly and disabled persons and/or persons with Alzheimer Disease, Category II residents. The census at the time of survey was nine. Nine resident files and three employee files were reviewed. The facility received a grade of D. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. The findings and conclusions of any investigation by the Division of Public and Behavioral Health 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. The following regulatory deficiencies were identified.			

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

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0178 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the exterior of the facility was maintained. Findings include: On 06/27/22 at 9:00 AM, the following were observed in the backyard: -Multiple bed frames. -A bedside commode. -A walker and a shovel. -A low hanging rope connected to two trees. The Administrator acknowledged the backyard was not maintained. The Administrator indicated all the equipment should have been removed. Severity: 2 Scope: 3	ID PREFIX TAG 0178	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator immediately instructed the Staff to removed and clean items mentioned. B. The Administrator and Staff from here on shall ensure that the backyard is free of the items mentioned or at least be placed in a well-maintained manner and would not cause impedance or trip hazards. C. Accomplished 6/28/2022	(X5) COMPLETION DATE 06/28/202 2

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0557 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure 3 of 9 sampled residents were free from the use of restraints (Resident #1, #2 and #9). Findings include: Resident #1 (R1) R1 was admitted to the facility on 06/07/22, with diagnoses including chronic heart failure. On 06/27/22 at 9:05 AM, R1 was observed lying in bed with half-length bedrails. R1 did not respond and was not able to be interviewed when asked whether R1 was able to remove the half-length bedrails independently. Resident #2 (R2) R2 was admitted to the facility 07/01/19, with diagnosis including Parkinson's disease. On 06/27/22 at 9:10 AM, R2 was observed lying in bed with half-length bedrails. R2 did not respond when asked if R2 was able to remove the half-length bedrails independently. Resident #9 (R9) R9 was admitted to the facility on 04/03/22, with diagnosis including Parkinson's disease. On 06/27/22 at 9:20 AM, R9 was observed lying in bed with half-length bedrails. R9 did not respond and was not able to be interviewed when asked whether R9 was able to remove the half-length bedrails independently. The Caregiver acknowledged R1, R2, and R9 were not able to lower the half-length bedrails independently. The Administrator acknowledged R1, R2 and R9 were not able to lower the half-length bedrails independently. The Administrator reported being unaware upper half-length bedrails were considered a form of restraint and were not allowed in the facility. Severity: 2 Scope: 1	ID PREFIX TAG 0557	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator immediately instructed the Staff to keep the half bedside rail down at all times and should only be used when turning side to side when cleaning up the Residents. B. The Administrator and Staff shall ensure that the half bedside rails are kept lowered at all times for all the Residents. C. Accomplished June 27, 2022	(X5) COMPLETION DATE 06/27/2022 2

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0620 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0620	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 07/07/202 2
	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on interview and record review, the facility failed to ensure a resident who required a urinary catheter was not admitted and retained (Resident #7). Findings include: Resident #7 (R7) R7 was admitted to the facility on 11/02/21 with diagnoses including dyspnea and urinary tract infections. On 06/27/22 at 9:30 AM, during a tour of the facility R7 was observed lying in bed, with a urinary catheter. R7 verbalized R7 was unable to care for the urinary catheter without assistance from staff. R7's file lacked documented evidence a medical exemption was obtained for the urinary catheter. The Administrator acknowledged the facility had not requested the required exemption waiver for a resident who was unable to care for a urinary catheter; and an application had not been submitted to the Bureau as of 06/27/22. There was no documented evidence sent to the Bureau of an exemption waiver application or approval for R7. Severity: 2 Scope: 1		A. The Administrator immediately informed the hospice agency that their client R7 requires a medical waiver for catheter. B. The Administrator and Staff from hereon shall ensure that any Resident that has and eventually would require a catheter shall be applied for with a medical waiver. C. Accomplished 7/7/2022	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0920 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the- counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure medications were kept in a secured and locked area. Findings include: Resident #3 (R3) R3 was admitted on 01/28/18, with diagnosis including right femur fracture. On 06/27/22 at 9:30 AM, during a facility tour, a medication cup was observed on R3's bed side table containing seven pills. R3's Ultimate User Agreement dated 06/13/18, documented the Caregivers of the facility were to possess and administer the resident's medications. The Caregiver acknowledged R3's medication should have been locked and secured. Severity: 2 Scope: 3	ID PREFIX TAG 0920	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator immediately had a discussion with the Staff. The Staff admitted got distracted of a call from another Resident and proceeded to assist but failed to secure said medications first. B. The Administrator and Staff shall ensure that when giving medications, Staff shall keep focus until the medications are given or if the assistance of the Staff is need by another Resident, the Staff shall secure the medications in the locked medication cabinet before proceeding to assist. C. Accomplished 6/28/2022	(X5) COMPLETION DATE 06/28/2022

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0936 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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. Inspector Comments: Based on interview and record review, the facility failed to ensure 2 of 9 sampled residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #5, and #6). Findings include: Resident #5 (R5) R5 was admitted on 11/01/19, with diagnoses including stroke and dementia. R5's file lacked documented evidence an annual TB test was completed. R5's last documented TB test was completed on 05/04/21. Resident #6 (R6) R6 was admitted on 08/03/15, with diagnoses including dementia and hyperlipidemia. R6's file lacked documented evidence an annual TB test was completed. R6's last documented TB test was completed on 05/04/21. On 06/27/22 at 11:00 AM, the Administrator acknowledged TB documentation was not in R5 and R6's file for review. The Administrator indicated the TB tests had not been completed annually, per the requirement. Severity: 2 Scope: 1	ID PREFIX TAG 0936	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator immediately conducted a signs and symptoms after the Annual Survey while scheduling for the TB Tests. TB Tests were done on July 1, 2022, for R5 and R6. Results are as follows: R6 negative R5 indeterminate, was rescheduled for another tests (Quantiferon) B. The Administrator and Staff shall routinely inspect the Resident Files to ensure that all requirements are updated and in compliance. C. Accomplished 7/1/2022	(X5) COMPLETION DATE 07/01/2022

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0991 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm system was activated on 1 of 3 doors exiting the facility. Finding include: On 06/27/22, at 9:05 AM, during a tour of the facility, the audible alarm system on one exit door leading to the backyard was not activated. The Caregiver acknowledged the alarm was not turned on. The Administrator indicated all door alarms should have been turned on. Severity: 2 Scope: 3	ID PREFIX TAG 0991	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator immediately purchased new sets of alarms and had it installed to ensure that it is operational. B. The Administrator and Staff shall routinely inspect or take note if any of the alarm are not operational so issues such as change of batteries, temporary shut off or malfunctions can be immediately addressed. C. Accomplished 6/30/2022	(X5) COMPLETION DATE 06/30/2022

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0992 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768. Inspector Comments: Based on record review, interview and document review, the Administrator failed to ensure the facility had established interaction groups of one Caregiver for every six residents during residents' waking hours. Findings include: On 06/27/22 at 9:00 AM, upon arrival to the facility, there was one Caregiver interacting with and assisting residents in the facility. The census was nine residents. The Caregiver #1 (C1) verbalized being the only Caregiver interacting with and assisting residents. C1 reported a second Caregiver was on the way to the facility, but had not yet arrived. The June 2022 staff schedule was posted on the wall in the dining area. The schedule documented three employees' names with no start or end time, who were scheduled to be working. The Administrator acknowledged there was one Caregiver on duty and nine residents when the Health Facilities' Inspectors arrived at the facility, and there should have been one Caregiver for every six residents. Severity: 2 Scope: 3	ID PREFIX TAG 0992	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A. The Administrator as mentioned during the Annual Survey, that one Staff resigned and C1 was on the way to assist. It was also mentioned that a new Staff is being hired who started on June 30, 2022. B. The Administrator shall ensure that there are appropriate number of Staff at all times. C. Accomplished June 30, 2022	(X5) COMPLETION DATE 06/30/2022

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2022
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(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) COMPLETION DATE
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp items were not accessible to residents. Findings include: On 06/27/22 at 9:00 AM, during a facility environmental tour, a pair of scissors, a pizza cutter and several knives were observed in an unlocked kitchen drawer. The Caregiver acknowledged the sharp items were unsecured. The Caregiver indicated all sharp items should have been locked up and not accessible to the residents. Severity: 2 Scope: 3	0994	A. The Administrator immediately instructed the Staff to lock the drawers containing the sharp items mentioned. B. The Administrator and Staff from hereon shall ensure that the kitchen drawers containing the sharp items mentioned are always kept locked and that the sharp items shall be returned in the cabinet and kept locked every after use. C. Accomplished 6/28/2022	06/28/2022
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 06/27/22 at 9:00 AM, the following toxic substances were accessible to residents and found in an unlocked bathroom and kitchen cabinet: -A bottle of Mr. Clean deep cleaning mist. - A bottle of disinfectant spray. -A bottle of all-purpose cleaner. -A bottle of Comet all-purpose cleaner. -A can of Comet powder cleaner. -Three bottles of perfume spray. The Caregiver acknowledged the toxic substances should have been secured. Severity: 2 Scope: 3	0999	A. The Administrator immediately instructed the Staff to remove and locked away all the items mentioned found in the bathroom and kitchen cabinets in the laundry room. B. The Administrator and Staff from hereon shall ensure that of the items mentioned are always kept locked in the laundry room and that said items shall be returned in the laundry room and kept locked every after use. C. Accomplished 6/28/2022	06/28/2022