Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10488	A. BUILDING _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVA ALL STAR CARE HOMES	5525 ROSE THICKET ST, LAS VEGAS, NEVADA ,89130

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State licensure and infection control survey conducted at your facility on 05/09/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, two Category I residents and seven Category II residents. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of A. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiency was identified:	0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ROBERT MARTINEZ Title: Administrator Date: 05/18/2023

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0557 SS= D	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 1 of 8 residents were free from the use of restraints (Resident #3). Findings include: Resident #3 (R3) was admitted to the facility 12/24/22 with diagnoses including hypothyroidism and iron deficiency. On 05/09/23 from approximately 9:15 AM to 11:30 AM, R3 was observed lying in a bed pushed up against a wall with a full length side rail in the up position on the opposite side. R3 did not respond when asked if R3 could lower the side rail independently. On 05/09/23 in the morning, the Owner acknowledged the full side rail was up and revealed staff kept a full side rail up because R3 was a fall risk and this kept them in bed. On 05/09/23 at 11:00 AM, the Administrator confirmed R3 had a bed pushed up against the wall and a full rail up on the other side due to a physician's order which indicated to do so. The Administrator was not aware a physician order was not acceptable to allow for a full bed rail to be put up causing the full bed rail to be used as a restraint. Severity: 2 Scope: 1	0557	1.) Deficiency was corrected by a.) immediately lowering the full railings on the Resident's bed and allowing the upper half-railings to be utilized only for mobility, if needed, and b.) requesting from the Resident's hospice company a set of fall mats. Hospice company was informed of the facility's State Survey on 5/9/23 and was also notified of the regulations prohibiting full bed railings. 2.) Ownership, Administrator, and Staff are now fully aware of the regulations prohibiting full bed railings, even regardless of having a physician's order. Ownership, Administrator, and Staff are now informed enough to educate Residents, their family members, and medical professionals on the prohibition of full bed railings in a group home facility. 3.) Ownership and Administrator will monitor Residents' beds to ensure no full railings are used, as Ownership and Administrator regularly visit the facility. Staff has been informed not to allow full bed railings as well. 4.) Administrator will monitor for compliance. 5.) Corrective action taken 5/9/2023	05/09/2023