

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2024	
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM		STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a voluntary re-grading State licensure survey conducted at your facility on 09/26/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 10 Residential Facility for Group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of survey was nine. Zero resident files and two 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 regulatory deficiencies were identified:	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 Name: TIANA SOSA Title: Manager Date: 10/31/2024
REPRESENTATIVE'S SIGNATURE

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(X4) ID PREFIX TAG 0994 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0994	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 09/26/2024
	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 objects were not accessible to residents. Findings include: On 09/26/24 at 9:25 AM, the kitchen drawer containing unsecured knives and other sharp objects was not locked. On 09/26/24 at 9:25 AM, the Caregiver confirmed the observation by opening the drawer without having to unlock it. The Caregiver showed a magnet that was supposed to be on the drawer that was located on the oven door next to the drawer. On 09/26/24 at 9:25 AM, a second Caregiver confirmed the drawer was not locked. On 09/26/24 at 9:25 AM, there was no activity taking place in the kitchen for the residents such as no cooking or cleaning taking place. On 09/26/24 10:43 AM, the Manager acknowledged the unsecured drawer and explained there was work being done on the kitchen cabinets and drawers and repairmen were working to fix the drawers, including adding new fixtures to secure the drawer with the knives and other sharp objects. On 09/26/24 at 10:45 AM, a Repairman reported working on the kitchen cabinets and drawers however the Repairmen were not present and working on the kitchen cabinets and drawers at the time of the observation. This was a subsequent deficiency from the 06/29/23 and 06/27/24 annual State Licensure surveys. Severity: 2 Scope: 3		1.The magnets were removed due to the drawer needing to be replaced and it was placed right back on 2.We check locks daily to ensure they are working properly 3.Staff sends pictures daily to ensure the locks are set in place 4.House lead 5.9/26/24 6.Document uploaded	

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(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
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 09/26/24 at 9:25 AM, the cabinet under the kitchen sink that housed toxic substances, including multiple bottles of various types of cleaning products, was not locked. On 09/26/24 at 9:25 AM, two Caregivers acknowledged the cabinet was not locked. On 09/26/24 at 9:25 AM, there was no activity taking place in the kitchen for the residents such as no cooking or cleaning taking place. On 09/26/24 10:43 AM, the Manager acknowledged the unsecured cabinet and explained there was work being done on the kitchen cabinets and repairmen were working to fix the cabinets, including adding new fixtures to secure the cabinet under the sink with the toxic substances. On 09/26/24 at 10:45 AM, a Repairman reported working on the kitchen cabinets and drawers however, the Repairmen were not present and working on the kitchen at the time of the observation. This was a subsequent deficiency from the 06/29/23 and 06/27/24 annual State Licensure surveys. Severity: 2 Scope: 3 This was a subsequent deficiency from the 06/27/24 annual State Licensure survey.	0999	1.The kitchen was being remodeled the cabinet locks were put back in place after they were painted 2.Caregivers send pictutres to ensure the locks are in place 3.Pictures sent daily 4. house lead 5.9/26/24	09/26/2024

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(X4) ID PREFIX TAG 1045 SS= C	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 1045	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 09/26/2024
	Placard - Display - NAC 449.27704 Placard: Issuance and display; failure to comply. (NRS 449.0302) 2. The administrator shall, within 24 hours after receipt of the placard, display or cause the placard to be displayed conspicuously in a public area of the residential facility. Inspector Comments: Based on observation and interview, the facility failed to display the B letter grade from the annual State Licensure survey dated 06/27/24. Findings include: On 09/26/24 at 9:22 AM, there was an A letter grade from the 06/29/23 annual State Licensure survey on the wall at the entrance of the facility. The B letter grade from the 06/27/24 State Licensure survey was not posted. On 09/26/24 at 10:50 AM, the Manager acknowledged the B grade was not posted. Severity: 1 Scope: 3		1.The new grade is hanging up 2.We will hang current grades when we receive them 3.Post new grades on wall when received 4.Manager 5.9/26/24	