DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MEAD CARE HOME	**4325 W LAKE MEAD BLVD, LAS VEGAS, NEVADA ,89108-2849**

(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 a complaint investigation completed in your facility on 05/30/24, in accordance with Nevada Administrative Code (NAC), Chapter 449. The census at the time of the survey was six. The sample size was six. The facility received a grade of A. There was one complaint investigated. Substantiated: Complaint #NV00070980 was substantiated (See Tag Y174). The investigation of the Complaint included: Observation of grooming and physical appearance of residents, interactions between caregivers and residents, odors in the facility, and cleanliness of the facility. Interviews were conducted with residents, caregivers, and the Owner. Record Review of six resident records, including the residents of concern, and six employee files. 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 deficiency was identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: GEOFFREY GOMEZ Title: Administrator Date: 08/06/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure there was no urine odor in the facility. Findings include: On 05/30/24 in the morning, a tour was conducted of the facility. The smell of cleaning agents and a faint smell of urine permeated the home. The urine smell was stronger in the room of Resident #3. On 05/30/24 in the afternoon, the Owner acknowledged the home smelled of urine, and verbalized Resident #3 soiled themselves frequently, causing the odor in their room. The Owner agreed additional efforts needed to be made to eliminate the pervasive urine odor in the home. Severity: 2 Scope: 3	0174	0174 a) All residents have the potential to be effected by the deficient practice. b) The faint smell of urine odor permeating the resident #3 room has been sterilized and made sure no offensive odor is present. c) The staff of the facility will ensure the to maintain a clean environment and free of any offensive odor. Completed: 5/30/2024	