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
	7213	A. BUILDING _____ B. WING _____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS CHATEAU FOR SENIORS	4175 N TOMSIK ST, LAS VEGAS, NEVADA ,89129

(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 completed at your facility on 12/21/22 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for five Category I and five Category II Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with Alzheimer's Category II residents. The census at the time of the survey was nine. Nine resident files and four employee files were reviewed. The facility received a grade of C. 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:	0000		
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation and interview, the facility failed to ensure a COVID-19 screening process including a temperature check was completed for all visitors upon entry into the facility. The survey team was not asked COVID-19 signs and symptoms questions and temperature checks were not obtained when they entered the facility. A caregiver confirmed they were not implementing COVID-19 screening processes because the facility was unaware it was still a requirement. Severity: 2 Scope: 3	0050	1. Lead caregiver and caregivers will make sure that Covid policies are still implemented, especially the signs and symptoms questions and the temperature is checked upon entry into the facility. This includes mask mandate when visiting the facility. 2. To make sure that this deficiency will not be occur, caregivers require all visitors to sign the signs and symptoms questionnaire upon entry, must check temperature and wear mask at. all times. 3. The corrective action will be monitored by the lead caregiver on daily basis to make sure the deficiency will not reoccur. Administrator will do a follow up check on regular basis until POC is implemented. 4. Lead Caregiver will make sure that the plan of correction is implemented. ADMINISTRATOR will check on regular basis to make sure that the implementation of the plan of correction is observed. 5. Correction was done on 12/21/2022 6. Please see attached copy of the visitors sign and symptoms questionnaire/ form.	12/21/2023

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: MARIANITA GEE Title: Administrator Date: 01/14/2023

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0178 SS= F	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 building was free of debris and items which could be harmful to residents. Large amounts of trash, rubbish, seven car tires, a shopping cart, old wheelchairs, a bed frame and construction materials were observed throughout the backyard. A caregiver confirmed the items listed were present in the backyard and needed to be removed or thrown away. Severity: 2 Scope: 3	0178	1. The debris were cleaned and thrown away. 2. To make sure that this deficiency will not reoccur, all trash, rubbish in the backyard will be immediately be thrown and picked up on a weekly basis. 3. For the corrective action to be monitored, the Lead Caregiver will make sure that the backyard will be free of trash and rubbish. Administrator will monitor on weekly basis. 4. The Lead Caregiver will make sure that the plan of correction is implemented. ADMINISTRATOR will check the backyard on regular basis, especially during visit to facility. 5. Corrective action was December 22-2022 6. Please see attached copy of the backyard photo.	12/22/2023
0527 SS= F	Activities for Residents - NAC 449.260 Activities for residents. (NRS 449.0302) 1. The caregivers employed by a residential facility shall: (b) Provide group activities that provide mental and physical stimulation and develop creative skills and interests; Inspector Comments: Based on observation, interview and document review, the facility failed to provide activities of interest for 10 of 10 residents. Findings include: On 12/21/22 from 9:00 AM to 11:30 AM, no activities were observed taking place and all residents remained in their rooms watching TV or sleeping. On 11/22/22 at 10:30 AM, Resident #1 and Resident #8 indicated the facility did not provide activities, but wished more activities were offered. Review of the Activity Calendar for December 2022 listed activities including waking up, watching the news, reading the newspaper and listening to music. Activity Calendar listed Videoke would be conducted from 10:00 AM to 11:00 AM on day of survey but was not observed to take place. On 12/21/22 at 10:15 AM, a Caregiver confirmed they do not conduct activities and have not asked residents what activities would interest them. Severity: 2 Scope: 3	0527	1. In order to correct a specific finding the activities' schedule was edited and changed. New activity schedule are implemented and are being followed. 2. In order for this deficiency not to reoccur, the activity schedule as written will be followed and practiced on daily basis. 3. The lead caregiver will follow and encourage residents to do activities according to the schedule. 4. Lead Caregiver will implement the plan of correction. Administrator will check and follow up Group Home at least once a week for the implementation of the new activity list/ schedule. 5. Date of corrective action was done December 22, 2022 6. Please see attached copy of the new activity form/ schedule.	12/22/2022

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0620 SS= E	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 observation, interview and record review, the facility failed to obtain exemptions to retain residents who were bedfast and unable to turn on their own without assistance for 2 of 9 residents (Resident #1 and Resident #9). Findings include: Resident #1 (R1) R1 was admitted on 11/11//21 with diagnoses including chronic obstructive pulmonary disease and hypertension. R1 was under the care of hospice. On 12/21/22 in the morning, R1 was asleep and a Caregiver reported R1 was not able to fully turn in bed without the assistance of a caregiver. There was no documented evidence of a bedfast waiver in the record of R1. Resident #9 (R9) R9 was admitted on 1/19/22 with diagnoses including dementia, hypertension, and blood clots. R9 was under the care of hospice. On 12/21/22 in the morning, R9 was unable to demonstrate the ability to turn in bed without the assistance of a caregiver. There was no documented evidence of a bedfast waiver in the record of R9. On 12/21/22 in the morning, the Caregiver acknowledged R1 and R9 required assistance to turn in bed and verbalized the need for bedfast waivers for R1 and R9. Severity: 2 Scope: 2	0620	1. In order to correct a specific deficiency, waiver to retain residents were submitted for approval. (Please see attached copies of approved waivers) 2. In order for this deficiency to not reoccur, the ADMINISTRATOR and Lead Caregiver will make sure that the waiver application is submitted before it's due date every year. 3. The corrective action will be monitored by checking the annual due date of waiver application annually and submit the application before it's due. ADMINISTRATOR will make sure that annual application is submitted before due date. 4. Corrective action was done January 12, 2023.. 5. Please see attached copies of the approval.	01/12/2023

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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 all chemicals were locked up and unavailable to residents. A large box of laundry detergent was observed in an unlocked laundry room. A caregiver indicated the laundry room was not able to be locked and the laundry detergent should have been locked in a cabinet and out of the reach of residents. Severity: 2 Scope: 3	0994	1. To correct this deficiency the laundry detergent is kept in a locked room. (see atatched photo) 2. In order for this deficiency not to reoccur caregivers are making sure that laundry detergent is kept in a locked room. 3. In order for this plan of action to be implemented, the laundry detergent, every after use, must be returned to the locked room bgy caregivers. 4. The Lead Caregiver is responsible for ensuring that the plan of correction is implemented. ADMINISTRATOR will check on regular basis to make sure that this plan of correction is being implemented. 5. Date of corrective action is Dec 22, 2022. 6. See attached copy of pictures.	12/22/2023
1540 SS= F	Cultural Competency Training Inspector Comments: Based on interview and record review, the facility failed to: submit an application for a cultural competency training program in compliance with R016-20; and ensure 4 of 4 employees were in compliance with Nevada Revised Statues (NRS) 449.103, regarding annual cultural competency training. The documented Cultural Competency training in the employee files was conducted by a non-approved training program. A caregiver confirmed the Cultural Competency training provided was from an unapproved program and had not been submitted for approval to the Bureau. Severity: 2 Scope: 3	1540	1. In order to correct the specific deficiency, all employees did the cultural competency training online.(see copies of trainings) 2. In order for this deficiency not to reoccur an annual training is required to all caregivers before it's due date. 3. In order for this deficiency not to reoccur, the administrator will make sure and monitor that the cultural competency training will be done annually before it's due date. 4. ADMINISTRATOR is responsible for ensuring that the plan of correction is being implemented. 5. Corrective action was done on January 12, 2023. 6. Please see attached copies of the trainings	01/12/2023