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 _____	**07/31/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA NORTE GROUP HOME	**4935 NORTH MILLER LN, LAS VEGAS, NEVADA ,89149**

(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 conducted at your facility on 07/31/19. This complaint investigation was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for 10 Residential Facilities for Group beds for persons with mental illnesses, chronic illnesses and/or Intellectual Disabilities, four Category I and five Category II residents. The census at the time of the survey was 10. Five resident files were reviewed and three employee files were reviewed. The sample size was 5 residents. There was one compliant investigated. Complaint #NV00058049 was substantiated. The allegation a resident washed walls as a form of behavior punishment and staff told resident to hit yourself was substantiated (See Tag 592). The following allegations could not be substantiated: Allegation #1: residents were not allowed any extra fluids at mealtime or throughout evening. Allegation #2: staff too busy to take resident on outing. Allegation#3: residents are weak because they don't get enough food to eat. The investigation into the allegations included: Observations of staff interaction with residents, lunch served included pizza and toss salad with ranch dressing, residents with water bottles in bed room and residents observed drinking sports juice, pantry stocked with food and drinks. Record Review of five residents including resident of concern. Interviews conducted with a two Behavioral Technicans, one Rehabilitation Technician and two Services Supervisor. Document review included staffing schedules, review of employee records and abuse policy. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: SHELLE SPONSELLER | Title: Administrator | Date: 08/19/2019

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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	other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0274 SS= F	Nutrition & Serivce of Food-Menu Substitution - NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the serving of the meal. Inspector Comments: Based on observation, interview, and document review the facility failed to ensure substitutions were posted on the current menu. Findings include: On 07/31/19 at 12:00 PM, the posted menu did not match the food being prepared for the lunch meal. The lunch menu dated 07/31/2019, documented the residents were to receive quesidillas, refried beans, Mexican rice and drinks. The lunch served on 07/31/19 consisted of pizza, tossed salad and juice. On 07/31/19 at 12:30 PM, a Services Supervisor acknowledged the current menu for July 2019 had not been followed and no substitutions were documented. The Services Supervisor indicated the menu should have been followed. Severity: 2 Scope: 3	0274	All current staff at Casa Norte will participate inre-training regarding the policies and procedures for amending the menu anddocumenting those amendments. This trainingis scheduled for August 27, 2019. Copiesof all menus will continue to be maintained on site for a minimum of 90-daysand then will be placed in file archive. All newly hired staff will receive food and nutrition training upon hireto include information on menu changes and documentation. The Site Supervisor will review the menuweekly to ensure that any and all changes were appropriately documented. The Program Administrator will completerandom QA reviews at the site and will verify that meals being served are whatare on the menu or have been altered in writing on the menu accordingly.	08/27/2019
0592 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity; Inspector Comments: Based on observation and interview, the facility failed to treat a resident with respect and dignity for 1 of 5 sampled residents (Residents #1). Findings include: Resident #1 (R1) R1 was admitted on 12/01/08, with diagnoses including	0592	The two accused staff members who were alleged to haveencouraged Resident #1 to hit himself and clean walls as a form of punishmenthave been terminated from their employment at Accessible Space, Inc. Neither has had contact with individuals'served since the allegations were made known to the Administrator, Director,etc. In order to prevent possibleincidents in the future of this nature, all staff currently working at CasaNorte will participate in a mandatory re-training of Client Rights, Dignity andRespect Training and Abuse, Neglect and Exploitation	08/27/2019

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	Tourette's disease and Impulsive disorder. On 7/31/19 at 11:19 AM, R1 verbalized R1 had cleaned the walls in the facility. R1 indicated two staff members had asked R1 to clean the walls. R1 reported the same two staff members had told R1 to hit himself in the face. R1 was unable to recall the date and time the incidents occurred. R1 verbalized not all the staff were bad, some were cool.. R1's Service Plan dated 02/01/19, documented R1 had a history of self-injurious behaviors. On 07/31/19 at 11:27 AM, a Behavior Technician indicated she had only worked with R1 for three days and had not seen extreme behaviors. The Behavior Technician indicated she was trained on R1's behavior plan to keep R1 safe. The Behavior Technician indicated R1 did have a history of self-injurious behavior and coping skills was part of the behavior plan to calm the resident. Resident #2 (R2) R2 was admitted on 10/05/11, with diagnoses of brain injury. On 07/31/19 at 11:35 AM, R2 verbalized a resident had been cleaning the walls in the facility. R2 indicated R2 had not been asked to clean the walls in the facility. R2 was unable to recall the date and time the incident occurred. On 07/31/19 at 11.50 AM, a Services Supervisor indicated she was recently made aware a staff member had asked R1 to wash the walls in the facility. The Services Supervisor verbalized the staff member had been placed on suspension 07/30/19. The Services Supervisor indicated she did not have an explanation, but received a call and letter regarding the compliant. The Services Supervisor indicated the facility had started an investigation into the allegation. The Services Supervisor indicated she was not a regular Supervisor at the facility. On 07/31/19 at 11:55 AM, the State Surveyor reported to the facility Supervisor the two staff members involved in the incident. Severity: 2 Scope: 1		training at a staffmeeting scheduled August 27, 2019. All hiredstaff in the future will continue to participate in Client Rights, Dignity andRespect and Abuse, Neglect and Exploitation training on the 1st dayof their New Hire training and prior to having any contact with the individualsthat we serve, as well as annually. The ServicesSupervisor will be on site regularly during the week to monitor interactionsbetween residents and staff and to ensure that incidents such as those reporteddo not happen in the future. Weeklymeetings will be held between the Services Supervisor and each resident tocheck in with them personally and give them an opportunity to report anyconcerns that they may be experiencing with their care. The Administrator will participate inimpromptu QA Reviews in the home and will meet with residents unannounced toensure quality services are provided. ASI’s Nevada Director will hold a Team Building Meeting with the staffat Casa Norte on August 29th to strengthen relationships andcommunication between staff in an effort to prevent incidents like this fromgoing unreported in the future.	