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
	7323	A. BUILDING _____ B. WING _____	09/18/2024

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 an annual State Licensure survey completed at your facility on 09/18/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, and/or persons with intellectual disability, four Category I and five Category II residents. The census at the time of the survey was nine. Nine resident files and thirteen 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 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		

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0557 SS= E	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 and interview, the facility failed to ensure full bed rails were not used as a restraint for 2 of 9 residents (Resident #1 and #7). Findings include: Resident #1 (R1) R1 was admitted on 05/20/16 with diagnosis of Traumatic Brain Injury (TBI). On 09/18/24 in the morning, R1 was observed lying in bed, with full bed rails up on both sides of the bed. R1 verbalized being unable to lower the bedrails. R1 was unaware the reason full bed rails were up on both sides of the bed, and acknowledged being immobile. On 09/18/24 in the afternoon, the House Manager acknowledged full bed rails were up on both sides on R1's bed and verbalized they were unaware they were considered a restraint. Resident #7 (R7) R7 was admitted on 06/03/16 with diagnosis of Fetal Alcohol Syndrome. On 09/18/24 in the morning, R7 was observed lying in bed, with full bed rails up on both sides of the bed. R7 verbalized being unable to lower the bedrails. R7 was unaware the reason full bed rails were up on both sides of the bed, and acknowledged being immobile. On 09/18/24 in the afternoon, the House Manager acknowledged full bed rails were up on both sides on R7's bed and verbalized they were unaware they were considered a restraint. Severity: 2 Scope: 2	0557	1) All staff have been retrained on the definitions of restraint and how the use of full bedrails constitutes as such. Staff have been instructed that at no times can the full rails that are part of the new beds be used. 2) Partial removable half bedrails have been purchased and are available to use. Staff and individuals have been provided training on appropriate use of half rails during transfers and any repositioning of a client into and out of bed. 3) Routine and spontaneous inspections will be completed during varying shifts to assure that full rails are not in use. 4) Administrator and Site Supervisor 5) 10/07/2024	10/04/2024