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 _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN SENIOR HOME GABRIEL	**2372 GABRIEL DRIVE, LAS VEGAS, NEVADA ,89119**

(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, complaint investigation, and infection control State Licensure survey completed at your facility on 01/18/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is 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 the survey was eight. The facility received a grade of B. There were two complaints investigated. Substantiated: 1. Complaint #NV00067442 was substantiated. (See Tag Y0515) Unsubstantiated: 2. Complaint #NV00067468 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaints included: Observation of grooming and physical appearance for residents and a tour of the facility. Interviews were conducted with residents and caregivers. Record Review of ten records, which included the residents of concern. Document Review included facility policy and procedures, hospital records, and incident reports. 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:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: DORA VALENTIN Title: Administrator Date: 03/09/2023

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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0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on interview and record review, the facility failed to ensure employees had current and/or initial first aid and cardiopulmonary resuscitation (CPR) training for 1 of 4 employees (Employee #4). Findings include: Employee #4 (E4) E4 was hired on 08/20/15 as an Administrator. E4's file lacked documented evidence of a current CPR certification. The previous CPR certification expired on 11/18/22. On 01/18/23 at 4:30 PM, E1 acknowledged E4's CPR certification had expired and E4's file lacked documented evidence of current CPR training. Severity 2 Scope 1	0106	Administrator put a calendar reminder to check on binder to make sure that staff printed out electronically sent info (However, CPR was completed and was emailed to surveyor by deadline	01/18/2023
0515 SS= G	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on interview, record review, and document review, the facility failed to provide protective supervision for one resident (Resident #10). Findings include: Resident #10 (R10) R10 was admitted to the facility on 03/01/22, with a diagnosis of Parkinson's disease, hypertension, peripheral neuropathy, dementia, and hyperbilirubinemia. R10's file included a Standard Physician's Assessment Form dated 02/25/22, which recommended R10 be placed in a facility that provides care to persons with Alzheimer's disease or related dementia as a Category 2 resident. A review of R10's	0515	The Administrator held a training for remaining staff in regard to Elopement and Alzheimer's as well as all Policies and Procedures on Sunday2/26/23. Employees that left door unlocked have been terminated. The door has been permanently locked and the other doors have the necessary sounds for each opening of the door. Administrator will remind staff monthly to communicate and document exit seeking behavior so that Administrator and Owner can have appropriate decisions	02/26/2023

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	Activity of Daily Living (ADL) Record for October, November, and December 2022 revealed R10 required assistance with bathing, dressing/grooming/hygiene, toileting, ambulation, indicated supervision was needed for behavior issues, and R10 could not sign the ADL Record due to physical limitations. On 11/14/22 at 8:00 pm, R10 was admitted to a hospital emergency room after Emergency Medical Services (EMS) were called when two people found R10 on the ground away from the facility after suffering a fall. A review of the hospital paperwork dated 11/18/22 indicated R10 left his group home to go for a walk and fell off a curb. The hospital paperwork revealed R10 suffered a mechanical fall after tripping over an uneven piece of pavement on the sidewalk, resulting in superficial lacerations to his head and face, as well as head pain. On 01/1/23 at 2:45 PM, Employee #1 (E1) was interviewed. E1 indicated on the morning of 11/14/22, while E1 and Employee #2 (E2) were in another resident's room assisting a resident out of bed, R10 eloped through a side door located in the facility's laundry room. E1 speculated the door leading to the laundry room from the kitchen must have been accidentally left unlocked while the two caregivers on shift were in another room assisting a resident. E1 revealed being unaware of the exact time R10 eloped, but E1 called the Administrator about 8:30 AM and 911 immediately after. E1 revealed R10 had been displaying exit-seeking behavior two to three times a day for several weeks prior to the elopement on 11/14/22. After being notified and arriving at the facility, the Administrator and a Caregiver began to search the neighborhood for R10 but were unable to locate R10. Responding Police Officers were given a picture of R10 including a physical description. R10 was unable to be located by responding Officers. The facility's policy titled Missing Person Plan indicated residents displaying exit-seeking or		and meetings completed to keep residents save.	

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	wandering behaviors would have an identification bracelet placed on the resident's wrist and if an exit-seeking attempt reoccurs within 30 days of the first incident, the Administrator will meet with the interdisciplinary team and the resident's family to discuss the circumstances of the reoccurrence(s), assess the potential for additional episodes, the potential for harm in additional episodes, and the potential of additional intervention strategies to prevent further occurrences. In addition, if the behavior continually reoccurs, cannot be redirected, and places the resident in constant jeopardy, the facility will be unable to continue to meet the needs of the resident, and the Administrator will designate a staff member to assist the family in finding more appropriate placement. The facility's policy titled Electronic Surveillance System indicated it is the facility's policy to use an electronic surveillance system that is worn by the resident to monitor mobile dementia residents at risk to wander outside into unsafe situations. On 01/18/23 at 2:10 PM, E1 acknowledged the facility failed to utilize an identification bracelet, a wearable electronic surveillance system, failed to complete a wandering risk assessment, meet with the interdisciplinary team, and/or assess R10's ability to remain in the facility. Severity: 3 Scope: 1 Complaint #NV00067442			
1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that	1540	The administrator and all staff and employees of the home areregistered for the March 31st session of the Nevada Health CareAssociation's approved training. Administrator submitted a course for approvaland ASHG as waiting for this class but it has yet to be approved.	03/31/2023

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	the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on record review and interview, 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 Statutes (NRS) 449.103, regarding initial cultural competency training. (Employee #1, #2, #3, and #4). Findings include: Employee #1 (E1) E1 was hired on 04/06/20 as a Caregiver. E1's file lacked documented evidence of initial and/or annual cultural competency training. Employee #2 (E2) E2 was hired on 11/02/19 as a Caregiver. E2's file lacked documented evidence of initial and/or annual cultural competency training. Employee #3 (E3) E3 was hired on 11/02/19 as a Caregiver. E3's file lacked documented evidence of initial and/or annual cultural competency training. Employee #4 (E4) E4 was hired on 08/20/15 as an Administrator. E4's file lacked documented evidence of initial and/or annual cultural competency training. Review of documentation lacked evidence the facility submitted a cultural competency training program to the Bureau of Health Care Quality and Compliance (HCQC). On 01/18/23 at 4:30 PM, E1 confirmed E1, E2, E3 and E4 had not completed an approved Cultural Competency Training Course initially and/or annually and confirmed the facility had not submitted a cultural competency training program to HCQC for approval. Severity: 2 Scope: 3			