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
	9545	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA PARADISE CARE, LLC	**1809 WESTWIND ROAD, LAS VEGAS, NEVADA ,89146**

(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 conducted at your facility on 06/28/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility was licensed for eight 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 six. Six resident files and three employee files were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9545	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA PARADISE CARE, LLC	1809 WESTWIND ROAD, LAS VEGAS, NEVADA ,89146

(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
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 implement safe infection control practices for the protection of residents in response to the COVID-19 pandemic. Findings include: On 06/28/21 at 11:00 AM, during an inventory count of personal protective equipment (PPE), the facility had no N95 masks. There were no employees fit tested and medically cleared to wear an N95 mask. Employees were not provided training on donning and doffing of PPE. The Owner acknowledged employees were not trained on donning and doffing of PPE and were not fit tested and medically cleared to wear an N95 mask. Severity: 2 Scope: 3	0050	N95 mask fitting for all staff of Home has been scheduled for completion on 7/18/2021. All Staff including the Owner will be N95 mask fitted and will be updated annually for all staff. Training will be conducted by N95 mask fitting service on properly donning and doffing PPE. Completed training certificates will be placed in employee files and will be updated annually. Administrator and/or Owner will ensure compliance on all new employees and annually on existing employees going forward.	07/13/2021
0178 SS= D	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 facility was maintained. Findings include: On 06/28/21 at 9:30 AM, the following were observed: -The backyard had several trees and shrubs brown in color with brittle branches. -The grass had brown and yellow weeds scattered throughout the backyard. - Small amounts of dog feces scattered throughout the backyard. -A mattress and bed rails were on the patio. The Owner acknowledged the backyard was not properly maintained. Severity: 2 Scope: 1	0178	Backyard was cleaned of all DME and other items as of 7/14/2021. Landscaper fixed the trees and shrubs affected on 7/14/2021 and will maintain monthly going forward. Owner and/or Administrator will monitor weekly going forward to ensure exterior is properly maintained.	07/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9545	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA PARADISE CARE, LLC	1809 WESTWIND ROAD, LAS VEGAS, NEVADA ,89146

(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
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on interview and observation, the facility failed to ensure 1 of 6 sampled residents had an ultimate user agreement (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 12/22/20, with diagnoses including dementia and hypertension. R1's record lacked documented evidence an ultimate user agreement was provided upon admission. On 06/28/21, the Owner confirmed the facility administered medications to the resident and there was no ultimate user agreement in R1's record. Severity: 2 Scope: 1	0876	Resident #1 Ultimate User agreement was signed and placed in file on 7/7/2021. Administrator audited remaining resident files and determined all other Residents had proper Ultimate User agreements signed. Administrator or Designee will monitor all new move ins to ensure the Ultimate User Agreement is signed going forward for all residents and Administrator will review all existing resident files monthly to ensure compliance going forward.	07/07/2021
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must	0878	Resident #6 medication was corrected on 06/28/2021. New order from Resident physician was received with correct medication bottle by pharmacy and MAR was updated. Administrator and/or Designee will monitor all med orders, MARS and medication bottles for all residents going forward on a daily basis to ensure compliance with physician orders and triple check system.	06/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9545	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA PARADISE CARE, LLC	**1809 WESTWIND ROAD, LAS VEGAS, NEVADA ,89146**

(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
	be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to ensure medications were given as prescribed for 1 of 6 sampled residents (Resident #6). Findings include: Resident #6 (R6) R6 was admitted on 03/25/21, with diagnoses including hypertension and dementia. A treatment medical list dated 03/26/21, documented a summary of R6's medications. The list included Losartan 100 mg tablet, take one tablet by mouth once a day. A Pharmacy Review dated 06/01/21, documented Losartan 100 mg tablet, take one tablet by mouth every day. R6's Medication Administration Record (MAR) dated June 2021 documented, Losartan Potassium 100 milligrams (mg) take one tablet by mouth every day. On 06/28/21 at 11:25 AM, R6's medication bottle was labeled Losartan Potassium 50 mg, take one tablet by mouth every day. On 06/28/21 at 11:30 AM, the Owner acknowledged R6's medication bottle did not match R6's MAR. The Owner confirmed there was a medication error. Severity: 2 Scope: 1			