3

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**8/3/2015**
Case No.:	**B-36123**
Administrator:	**Joan MacLennon**
License No.	**RFA 7070**
Admin of Record:	**4/15/15 to present**
Referral from:	**DPBH**
Survey Date:	**4/22/2016**
Survey due to:	**Annual Survey &Complaint Invesigation**
Facility:	**The Bridge at Paradise Valley** **2205 E. Harmon Ave.** **Las Vegas 89119**
Number of Beds:	**91**

PROPOSED DISCIPLINE

Legal Fees:	$ **902.23**
Admin Cost:	**375.00**
Training Cost:	**0.00**
Training:	**Regulation Training**

DATE OF SURVEY 5/18/2015

The facility received a grade of C.

Complaint #NV00042644 contained one allegation. The complaint was substantiated.

Allegation: Quality of care, resident safety/falls. The allegation was substantiated. See Tag Y0515.

Complaint #NV42648 contained one allegation. The complaint was substantiated.

Allegation: Quality of care, resident safety/falls. The allegation was substantiated. See Tag Y0515.

Complaint #NV00042284 contained one allegation. The complaint was substantiated.

Allegation: Quality of care, resident safety/falls. The allegation was substantiated. See Tag Y0515.

Y 050 NAC 449.194(1) Administrator's. Responsibilities-Oversight

Based on record review, interview and policy review, the administrator failed to provide oversight and direction to staff during a gastrointestinal (GI) outbreak; failed to report to the Office of Public Health Informatics and Epidemiology (OPHIE) the occurrence of a communicable disease in a timely manner, and failed to obtain the necessary tests to prevent the spread of disease.

- Review of the Interjurisdictional Notification Form dated 4/21/15 documented a gastrointestinal (GI) outbreak with first illness onset date of 4/12/15. The report came in nine days after the first case. A total of 86 residents and staff were exposed; 24 reported symptoms of vomiting and diarrhea and four were hospitalized. No testing had been arranged at the time of reporting.

On 4/22/15, an additional three residents were reported to have symptoms of vomiting and diarrhea. There were no new cases reported beginning 4/24/15.

- The facility was advised of the process for receiving orders for stool sampling for any future outbreak cases.

- The facility was provided GI outbreak management toolkits, CDC guidelines and additional education material.

- The facility was advised to modify their infection control policy to indicate when to report outbreaks to the Office of Public Health Informatics and Epidemiology (OPHIE).

- Review of the Investigation and Management of Outbreaks of Known or Suspected Norovirus in Long Term Care Facilities (Revised May 2010) that read in part:

"... Reporting Requirements: As with all group outbreaks, facilities should report suspected norovirus outbreaks to the local public health agency or state health department within 24 hours..."

Severity 2 Scope 3

YO74 NRS 449.093 Elder Abuser Training

Based on record review and interview, the facility failed to provide documented evidence of training on recognition and prevention of elder abuse for 6 of 10 employees. (Employees #1, #2, #6, #8, #9 and #10).

- Review of personnel records revealed the following employees lacked evidence of elder abuse training prior to providing services:

Employee #1 was hired on 3/25/15 as a medication technician and caregiver.

Employee #2 was hired on 3/18/15 as a caregiver.

Employee #6 was hired on 3/18/15 as a caregiver.

Employee #8 was hired on 3/25/15 as caregiver.

Employee #9 was hired on 4/17/15 as General Manager.

Employee #10 was hired on 2/9/15 as Resident Care Director.

- On 5/6/15, at 3:00 PM, the General Manager and Resident Care Director explained the new employee orientation included training on abuse and neglect.

- Review of the Orientation Agenda showed from 3:15-4:15 PM, the topic on Working with Seniors, Abuse and Neglect and Resident Rights were discussed. There was no documented evidence the training covered recognizing elder abuse, including sexual abuse; who is a mandatory reporter; responding to reports of alleged abuse; who to report elder abuse to; and that it included information covered in NRS 200.5091 to 200.50995. Copies of completed tests and certificate of completion were not found in employee files.

Severity:2 Scope: 3

Y102 NAC 449.200(1)(c) Personnel File- Training Records

Based on record review and interview, the facility failed to provide documented evidence of completion of caregiver training for 9 of 10 employees. (Employees #1, #2, #3, #4, #5, #6, #8, #9 and #10).

- Review of personnel records revealed the following employee files lacked evidence of initial caregiver training that included an outline of the materials covered and date of completion.

Employee #1 was hired on 3/25/15 as a medication technician and caregiver. Employee #2 was hired on 3/18/15 as a caregiver.

Employee #3 was hired on 11/24/15 as a medication technician and caregiver. Employee #4 was hired on 10/6/14 as a caregiver.

Employee #5 was hired on 9/10/14 as a medication technician and caregiver. Employee #6 was hired on 3/18/15 as a caregiver.

Employee #8 was hired on 3/25/15 as caregiver. Employee #9 was hired on 4/17/15 as General Manager.

Employee #10 was hired on 2/9/15 as Resident Care Director.

- Review of the Orientation Agenda revealed from 3:15-4:15 PM (one hour), the following topics were covered: Working with Seniors, Abuse and Neglect and Resident Rights.

- On 5/6/15, at 3:00 PM, the General Manager and Resident Care Director explained the new employee orientation included the caregiver training. In addition, a three-day (total 24 hours) of caregiving shadowing was completed for new caregivers. However, certificates were not provided and the inservice sign-in sheets did not document the specific topics covered and date of completion.

Severity:1 Scope: 3

Y178 NAC 449.209(5) Health and Sanitation-Maintain Int/Ext

The Administrator failed to ensure the interior and exterior premises were clean and well-maintained.

- On 5/6/15 from 8:40 AM, during a tour of the facility with the Maintenance Director, the following were observed:

1) At the front patio, next to main entrance, several "No Smoking" signs were posted; however, an ashtray/receptacle was found next to a bench. Two residents in front of the building were non-smokers, and one had an oxygen tank. On 5/6/15 at 9:00AM, the Maintenance Director indicated residents refused to follow the "No Smoking" sign and kept smoking in front of the building; that's why he moved the receptacle to this non-smoking area.

2) In the interior courtyard, 13 cigarette butts were found on the ground. No designated smoking area or non-smoking area was found in the courtyard.

3) In the hallway near Room 101, the vent was dusty.

4) On the first floor personal laundry room, the dryer was out of order.

5) In Rooms 122 and 235, there was strong urine smell. There was a dog in Room 122 and several puppy pads.

6) While inspecting the outside perimeter of the building, it was observed there were missing window screens in two small windows at the interior courtyard, north upstairs window, southeast corner window and downstairs breakroom window. The Maintenance Director indicated they were remodeling and would replace all screens.

7) On the west side of the building, there was warped/damaged table and broken chair stored. The Maintenance Director explained they were put to the side for disposal.

8) In the downstairs common restroom, the toilet paper dispenser was empty.

9) The first floor locked restroom (near reception) had slow draining sink.

Severity 2 scope 3

Y255 NAC 449.217(6)(a)(b)Permits - Comply with NAC 446 on Food service

Based on observation on 05/06/15, the facility failed to ensure the kitchen complied with the standards of NAC 446.

Findings include:

1. Critical Violations:

a. There were multiple dented cans (beans and 3 tropical fruits) found in dry storage.

2. Major Violations:

a. Storage drawer handles and walls in the dish room were soiled with food debris and grime.

Severity: 2 Scope: 1

Y431 NAC 449.229(2) State Fire Marshall referral

Based on observation and interview, the facility failed to comply with State Fire Marshall regulations.

- On 5/6/15, from 8:40 AM, during a tour of the facility with the Maintenance Director, the following were observed:

1) One fire extinguisher next to employee break room did not have the inspection tag. The Maintenance Director indicated "someone snipped them off."

2) The fire extinguisher in the maintenance room had an inspection tag dated 10/1/13. Another tag had a date of 4/7/14.

3) Reports for Monthly Fire Drills conducted on 3/19/15, 4/9/15 and 5/4/15 were provided; however, the preceding nine months were not available for review at the time of survey. 4) The May 2015 Smoke Detector Test documentation was conducted; however, the report did not include the results of test. The preceding eleven months of reports were not available for review at the time of survey.

Y515 NAC 449.259(1)(a) Supervision of Residents

Based on record review, interview and policy review, the facility failed to provide necessary evaluation and individualized service plan to 3 of 11 residents who were at risk for falls. (Residents #2, #6 and #11).

Resident #2 was admitted on 1/20/15 with diagnoses including anemia, atrial fibrillation and chronic low back pain.

The Physician's Report dated 1/25/15 documented the resident's primary diagnosis was debility and secondary diagnosis was left proximal femur fracture, gait instability, impaired assistance with daily living (ADL), atrial fibrillation and anemia.

- The Service/Functional Assessment dated 1/30/15, failed to identify the resident's fall risk factors.

- There was no evidence of an initial Fall Risk Evaluation.

- The Service Plan did not include fall prevention and intervention.

- Review of Incident Reports revealed:

On 4/2/15 at 10:12 PM, documented the resident had a fall without injury. The immediate preventive measure was: "Gave the walker, closer to her and her wheelchair; reminded not to get up without any of it."

On 4/22/15 at 5:35 pm, documented the resident was found laying on the floor after they got up to turn the TV off. The resident complained of pain on right (sic) hip and was unable to move. The immediate preventive measure was: "Spoke to resident to always have the pendant on, and to call for help instead of risking self."

- The Physician Communication dated 4/22/15 reported the resident was sent to a hospital due to a fall. The resident complained of pain on right(sic) hip and could not move.

On 4/22/15 at 3:00 PM - The hospital informed the facility, the resident had left hip fracture, but did not require a surgery.

Resident #6:

Resident #6 was admitted on 5/1/08 with diagnoses including atrial fibrillation, anxiety, hypertension, osteoporosis, congestive heart failure diabetes mellitus type II. The resident had a pacemaker. Past surgical history included open reduction internal fixation (ORIF) of the right hip.

- The Post Hospitalization Evaluation dated 9/18/14 documented the resident had a fall the previous week. The resident tripped on the walker while walking, hit the head on glass cabinet and sustained lacerations and bruised lower and upper extremities. The resident was transferred to a hospital for treatment.

- Service/Functional Assessment dated 11/28/14 documented risk factors including history of falls, high risk medications: antihypertensives, sedatives, anti-anxiety, narcotics and long-term use of anticoagulants.

- There was no documented evidence of Fall Risk Evaluation. The Service Plan failed to identify the resident's fall risk factors and did not include fall interventions.

- Review of Incident Report revealed:

On 3/31/15 at 10:20 PM, the resident was found laying on the floor after they tripped on the walker. The resident complained of pain on the right chest area; observed abrasion on the pacemaker area. The immediate preventive measure was: "Spoke to resident to look first and make sure there is no any block (sic) on her walker before going anywhere."

On 4/24/15 at 10:00 PM, the resident was trying to go to the bathroom when they fell. The resident was observed leaning on the right side and demonstrated severe pain. There was no immediate preventive measure documented.

- Progress Notes dated 4/25/15 at 9:00 AM, documented the hospital informed the RCD the resident had two broken ribs and was admitted due to decreased oxygen levels. The resident remained in ICU until the last progress notes dated 4/30/15. As of 5/6/15 (survey date), the resident was still in the hospital. Resident #11:

Resident #11 was admitted on 10/8/11 and lived with the spouse in the same apartment. The resident had diagnoses including orthostatic hypotension and diabetes mellitus type II.

- The Service/Functional Assessment dated 1/15/15 documented the resident had "several falls" as risk factor. Safety Concerns included: Fall safety. Risks included orthohypotension, weakness and use of high risk medications including narcotics/antihypertensives.

- There was no documented evidence a Fall Risk Evaluation was performed upon admission and after the 1/15/15 Functional Assessment. An updated Service Plan was not developed; as a result, fall interventions were not implemented.

- Review of Incident Reports revealed:

On 2/13/15 at 9:25 AM, the resident was found sitting next to recliner. Resident stated they were in a hurry, tried to reach the walker, unlocked it too soon and fell. The resident did not complain of pain. The preventive measure was: "Reminded resident to press her pendant whenever she needs assistance."

On 3/3/15 at 9:30 PM, the resident was found sitting on the floor after they slid on the side of the walker. The preventive measure was: "Use walker at all times."

On 3/9/15 at 4:38 AM, the resident was found laying on back in the bedroom They stated they slid from the right corner edge of her bed while trying to reach for her clothing in the drawer. They were able to walk, no bruise or redness observed. The resident refused to be sent to the emergency room. The preventive measure was: "Resident was advised that if she needs help, and not feeling well or feeling unsteady, press her pendant and call staff for help."

On 3/9/15 at 8:43 AM, the resident was found sitting on the floor in front of recliner. They stated they were trying to sit on the recliner but failed to go back further and missed the chair. No complaint of pain. The preventive measure was: "Resident was advised to ask staff for help in getting up."

On 3/11/15 at 5:58 AM, the resident's spouse called for help after finding the resident on the bathroom floor. The resident lost balance while trying to reach for something in the drawer and fell backwards. The preventive measure was: "Resident was reminded to always push pendant for help."

The resident sustained a sub-arachnoid bleed to the brain and was placed on ventilator. The resident passed away on 3/22/15.

- There was no documented evidence a Fall Risk Evaluation was performed after four falls in March 2015. As a result, the Service Plan was not updated and fall prevention interventions were not implemented.

- The Resident Status Notes dated 3/11/15 documented the RCD spoke with the daughter who was concerned about frequent falls. The RCD indicated they would review the medications with the physician before the resident returned.

- On 5/6/15 at 4:30 PM, the General Manager and Resident Care Director explained a new assessment was not completed because the resident did not come back to the facility after the last fall.

Review of Fall Management and Risk Assessment Policy (dated 9/1/14), that read in part:

"...Procedure:

1. All residents must be assessed for their fall risk. Those residents identified as 'at risk' must have a Fall Risk Evaluation completed: a. On admission to the community. b. Following any change of condition. c. Following a trend in falls - more than 3 falls in 1 month period..."

Severity: 2 Scope: 2

Y859 NAC 449.274(5) Periodic Physical Examinations of a Resident

Based on record review and interview, the facility failed to ensure 2 of 11 residents completed the required annual physical examination (Residents #6 and #7).

Resident #6 was admitted on 5/1/08 with diagnoses including atrial fibrillation, anxiety and diabetes mellitus type II. Review of resident records revealed no documented evidence a physical examination was completed in 2013.

Resident #7 was admitted on 4/10/12 with diagnoses including hypertension, generalized anxiety disorder (GAD) and osteoarthritis (OA). - Review of resident records revealed no documented evidence a physical examination was completed in 2014.

- On 5/6/14 at 11:30 AM, the General Manager indicated they were aware of missed physical examinations in the past year.

Severity:2 Scope: 1

Y871 NAC 449.2742(1)(d)(1-8)(1)(e) Medication Plan

1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall:

d) Develop and maintain a plan for managing the

administration of medications at the residential facility, including, without limitation:
(1) Preventing the use of outdated, damaged or contaminated medications;

(2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are

ordered, filled and refilled in a timely manner to avoid missed dosages;

\(3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744;

(4) Monitoring the administration of

medications and the effective use of the records of

medication administered to each resident;

(5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196;

(6) Ensuring that each caregiver who administers a medication is adequately supervised;

(7) Communicating routinely with the prescribing physician or other physician of the resident concerning issues or observations relating to the administration of the medication; and

(8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications.

(e) Develop and maintain a training program for caregivers of the residential facility who

Based on record review and interview, the facility failed to ensure an "as needed" medication was onsite for 1 of 11 residents (Resident #5).

Resident #5 was admitted on 1/23/15 with diagnoses including chronic obstructive pulmonary disease (COPD), hypertension, debility and anxiety.

- Review of May 2015 Medication Administration Record (MAR) revealed ProAir HFA with dose counter 90 micrograms, inhale two puffs by mouth every four hours as needed for shortness of breath, was preprinted on MAR by the pharmacy. This medication was not onsite.

- On 5/6/15 at 4:55 PM, the Assistant to Resident Care Director indicated the family member was going to bring ProAir to the facility that afternoon.

Severity:2 Scope: 1

Y 920 NAC 449.2748(1-2) Medication Storage.

Based on observation and record review, the facility failed to ensure prescription and over-the-counter medications were kept in secured location.

- On 5/6/15, during a tour of the facility, the following were observed:

1) In Room 237, Nyquil, Dayquil and Coricidin were found on the resident's nightstand. Review of resident's file revealed on 4/27/15, these medications were discontinued. There was no doctor's permission to self-administer these medications.

2) In Room 246, Preparation H Ointment was found on the bathroom counter. It was not listed on MAR.

Severity:2 Scope: 1

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**11/19/2015**
Case No.:	**B-36133**
Administrator:	**Susan Sowers**
License No.	**RFA 9054**
Admin of Record:	**12/11/14 to 7/30/15**
Referral from:	**DPBH**
Survey Date:	**8/4/2015**
Survey due to:	**Non-grading State Licensure Survey and 2 Complaint Invesigations**
Facility:	**Red Rock Residential Care Center 5975 W. Twain Ave. Las Vegas 89103**
Number of Beds:	**83**

SETTLEMENT

Legal Cos	$ **857.62**
Admin Cost:	**375.00**
Probation:	**Respondent shall be placed on Probation and maintain a grade of B or better for all of her facilities for the 18 months immediately following the effective date of the Board's Final Order.**
Training:	**Regulation training to be provided by the Board**

DATE OF SURVEY 8/04//2015

Y 050 449.194(l) Administrator's / Responsibilities-Oversight

Based on observation, interview, record review and policy review, the Administrator failed to provide oversight and supervision to the staff, to ensure residents received the necessary
services. :

See Tags Y072, Y178, Y181, Y253, Y255, Y276, Y471, Y503, Y599, Y693, Y878, Y883, Y895, Y920, Y936, Y955 and Y1005.

Severity: 2 Scope: 3

Y 072 NAC 449.196(3)(a-c) Qualifications of Caregiver-Med Training

Based on observation, interview and document review, the facility failed to ensure I of 13 employees provided satisfactory evidence the employee completed the required eight hours of Medication Management Training annually (Employee #5).

Employee #5 was hired on 2/21/12 and was the current the Medication Technician Supervisor. - Review of personnel records revealed a certificate documenting the employee had successfully completed eight hours of Medications Assistance Refresher training and passed the examination on December 4, 2013. The certificate was printed on a stationery with the Nevada State Health Division, Bureau of Health Care Quality & Compliance (BHCQC)
heading and the state seal.

For the 2014 annual training, a document with Employee #5's name certified the employee had successfully completed 8 hours of Medications Refresher training and passed the examination on December 12, 2014. The certificate was printed on a plain paper without the Nevada State Health Division, BHCQC heading and without the state seal. The employee's name, test date and expiration date appeared pasted and copied. - On 7/1/15 at 12:10 PM, Employee #5 indicated she paid for the class, so that she kept the original certificate. The employee was requested to present the original certificate for review on the second day of survey, but was unable to do so.

- On 7/2/15 at 11:40 AM, a staff at the training center verified they did not provide Medication Management Refresher class on 12/12/14, and
the certificates they issued had the BHCQC heading and state seal.

- On 7/8115 at 4:20 PM, the instructor whose signature appeared on the document, indicated they would not honor the 2014 certificate because it did not have the BHCQC heading and state seal. The instructor verified the Medication Management Refresher class was not conducted on 12/12/14.

- Review of the December 2014 schedule of classes provided by the instructor at the training center revealed the Medication Management Refresher class was held on 12/21/14, and not on 12/12/14 as noted on the employee's certificate.

Severity,2 Scope:1

Y 178 NAC 449.209(5) Health and Sanitation-Maintain Int/Ext

Based on observation, the Administrator failed to ensure the interior premises were clean and well maintained.

- On 7/1/15 and 7/2115, in the morning and afternoon, during a facility inspection, the following were observed:

1) The front entrance door had loose handle.
2) In Room 107, there was strong urine smell.
3) In Room 202, the window screen was not
Installed.

- On 711/15, the facility Maintenance Supervisor acknowledged items 1) and 2) findings.

This was a repeat deficiency from the 1/28/15 survey.

Severity: 2 Scope: 3

Y 181 NAC 449.209(8) Health and Sanitation-Temperature

Based on observation and Interview, the Administrator failed to keep the facility within the required temperature.

- On 7/1/15, In the morning, during the environmental inspection, using a calibrated thermometer, the following were observed:

1) At 9:20 AM, in Room 118, the thermostat was set at 74 degrees Fahrenheit; however the resident's room registered at 82.4 degrees Fahrenheit
2) At 9:30 AM, In the hallway near Room 126, the thermometer registered 82.2 degrees Fahrenheit.
3) At 10:20 AM, the thermostat In the hallway near Room 216, read 69 degrees Fahrenheit.
4) At 10:28 AM, in Room 222, the temperature was 82.8 degrees Fahrenheit. The resident indicated they were having seizures due to heat.

5) At 1:45 PM, the hallway near Room 217 registered 83.1 degrees Fahrenheit. 6) At 1:45 PM, the Activity Room on the second floor registered 83.1 degrees Fahrenheit. 7) At 1:45 PM, the vending room on the second floor registered 83.7 degrees. There were oxygen tanks in that area. A resident present in this room Indicated the air conditioning had been out for four days.

8) At 2:00 PM, by the stairs next to Room 228, the area registered 85.3 degrees Fahrenheit. The Medication Technician complained of heat.

- On 7/1/15 at 11:30 AM, the Executive Director indicated there were five new air conditioning units to be delivered on 7/2115.

- A Work Order (undated) documented new air conditioning units for Rooms 108, 112. 114, 116 and 201 were to be delivered on 7/2/15.

Severity: 2 Scope: 3

Y 253 NAC 449.217(4) Adequate Supplies of Food

Based on observation and Interview, the facility failed to ensure enough food was

available per meal, and at least a two-day supply of fresh food and one week supply of canned food were available at all times.

Findings Include:

- On 7/1/15 from 8:30 AM, the following were observed:

Dry:
1 can 6 pound 15 ounces mandarin oranges
2 cans 28 ounces fire roasted red peppers
2 cans 6 pound 15 ounces tomato paste
7 boxes 8 count granola bars
2 boxes 10 count cheese sandwich crackers
30 bags 1 ounce potato chips
24 boxes 16 ounces powdered sugar
11 envelopes 2 3/4 ounces sugar free gelatin
3 bags 8.6 ounces fruit punch mix
8 packets 5 ounces sugar free pudding
5 containers 42 ounces instant oatmeal
4 to 5 large bags of pasta

Refrigerated:

3 watermelon
3 cantaloupe
1 box of eggs
I bag of fresh vegetables
1/2 bag of mixed vegetables
Tomatoes, onions and potatoes
Packets of tartar sauce and mayonnaise
1/2 bag of sweet potato fries
20 pounds of 6 oz bags of green peas
20 pounds of 6 oz bags of peas and carrot mix

Frozen:

17 hamburger patties, the package was not sealed; the Food Service Director discarded then
12 pack box flat bread pizza crusts
I bag of wheat rolls
1 20 pound box green peas
1 20 pound box peas and carrots mix
1/2 bag of mixed vegetables.
1/2 bag of sweet potato fries

- On 7/1115, In the morning, observed a pot of boiling chicken. The Food Service Director indicated it would be used for salads.

- The 7/1115 menu listed Turkey ala King for lunch. During the Inventory of refrigerated and frozen food, turkey meat was not found.

- On 7/1/15 before 11:00 AM the food company delivered refrigerated and frozen food. The food invoice for 7/1115 delivery did not include refrigerated or frozen turkey.

- On 711/15, at 11:30 AM, the residents were served Turkey ale ling for lunch. It was observed the meal had white chunks of meat. When asked where the turkey came from, the Food Service Director Indicated they had leftover turkey in the refrigerator. The amount of leftover
turkey was undetermined.

- The last delivery of 23 pounds of turkey breast and thigh roasted was on 6/12115. On 6114/15 the facility served Turkey Tetrazzini, and on 6/17/15, Herbed Turkey. If they served 10 pounds of meat per meal, the turkey breast and
thigh would have been used up after 6/17/15.

Severity.2 Scope: 3

Y 255 NAC 449.217(6)(a)(b) Permits Comply with NAC 446 on Food Service

Based on observation on 07/01/15, the facility failed to ensure the kitchen complied with the
standards of NAC 446.

1. Major Violations:

a. Washed, rinsed, and sanitized pans were stacked in storage while still wet

b. A server station sanitizer bucket contained an undetectable amount of sanitizer.

c. The meat slicer was soiled with food debris. d. The server station ice bin was soiled with grime.

d. The server station sanitized ice bin was soiled with grime.

e. A waste receptacle was not provided at the hand washing sink in the kitchen.

f. Paper towels were not in the dispenser at the server's station hand washing sink.

g. A cup and dumped milk were in the server station's hand washing sink.

h. There was a foul odor coming from the grease trap.

i. Lids to the outside dumpsters were open.

Severity:2 Scope: 3

Y 276 NAC 449.2175(7) Nutrition and Service of Food

Based on observation and interviews, the facility failed to provide food services that were suitable for the residents, and failed to ensure sufficient servings of meat entrees were available.

On 7/1/15 and 7/2/15 at lunch time, comments from 23 residents were as follows:

- Six residents reported they were satisfied with the food taste and. portions; they can get second if they asked; this was an improvement from a few months ago:
- Four residents indicated they were served a lot of pasta; three to five times a week.
- Three reported they could not get hot breakfast after 7:30 AM. Some residents were unable to
get up early to have hot breakfast, so they eat cold cereals.
- Two residents indicated they serve a lot of meatloaf. The meatloaf portion was small about 4 x 4 inches.
- Two residents reported hamburgers were not cooked properly, "served raw."
- One resident Indicated the meals were not well planned. Examples given were quesadilla and beets, tuna sandwich and mashed potatoes.
- One resident reported they were not given condiments for hamburgers; no mustard, mayonnaise or onions.
- One resident reported they would sometimes run out of food shortly after they started serving.
- One resident reported food was not served warm enough.

- One resident Indicated the portions were small; sometimes they had enough for second serving and sometimes they did not.
. - One resident indicated for dinner they served baked potato with cheese and bacon once a week; not enough for a meal.

- On 7/1/15, In the morning, the Food Service Director Indicated they never run out of food, and
that hot breakfast was available after 7:30 AM, if requested.

- Food deliveries were scheduled on Wednesday and Friday. An analysis of meat purchases versus lunch and dinner menu, revealed the facility had sufficient amount of

meat for at least one week. Leftover meats were used for the following week's entrees on the menu. However, it appeared insufficient amount of meat/protein was prepared for each meal.

- On 7/1/15 at 9:30 AM, the Food Service Director explained they ordered meat based on the menu, usually twenty pounds at a time and would use approximately ten pounds of meat per meal.

- The Menu Guide Report showed a typical serving of protein was three ounces. It was calculated that ten pounds or 160 ounces of meat per meal, would produce 53 servings of meat/protein. The facility's census at the time of survey was 68.

-'On 7/10115 at 8:50 AM, the facility's Registered Dietitian consultant indicated 10 pounds of meat per meal would not be enough for 68 residents if they followed the standard portion of three ounces of meat or protein per meal.

This was a repeat deficiency from the 1/28/15 survey.

Severity 2 Scope: 3

Y471 NAC 449.232(2) List of Telephone Numbers

Based on record review, the facility failed to ensure 3 of 15 residents had their physician's name and phone number readily available in case of emergency (Residents #8, #10 and #11).

Review of resident records revealed the following did not have the name and phone number of their primary care physician in file:
- Resident #8 was admitted on 11/20/12 with diagnoses including memory deficit and chronic obstructive pulmonary disease.
- Resident # 10 was admitted on 6/9/15 with diagnoses including traumatic brain injury and memory loss.
- Resident #11 was admitted on 12111/14 with diagnoses including insulin dependent diabetes mellitus (IDDM) and neuropathy.

Severity:2 Scope: 1

Y 503 NAC 449.258(4) Employee Compliance with Written Policies

Based on record review and interview, the facility failed to ensure it followed it's policy regarding resident move-in and move-out for 3 of 3 residents (Residents #16, #17, and #19).

Findings include:

On 8/4/15, a review of resident files revealed the following:

- Resident #16 was admitted on 7/6/12. Review of the resident's file revealed a lack of documented evidence of an inventory checklist upon move-in and prior to discharge. The file also lacked documented evidence of the resident's discharge date.

- Resident #17 was admitted on 8/3/13. Review of the resident's file revealed a lack of documented evidence of an inventory checklist upon move-in and prior to discharge. The file also lacked documented evidence of the resident's

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**1/7/2016**
Case No.:	**B-36135**
Administrator:	**Gerald Hamilton**
License No.	**RFA 9369**
Admin of Record:	**9/02/14 present**
Referral from:	**DPBH**
Survey Date:	**10/20/2015**
Survey due to:	**Annual State Licensure Survey**
Facility:	**Bee Hive Homes of Mesquite** **780 W. Second St.** **Mesquite 89027**
Number of Beds:	**15**

PROPOSED DISCIPLINE

Fine:	$ **3,000.00**
Admin Cost:	**375.00**
Training Cost:	**150.00**
Training:	**Best Practices Modules 1, 4 & 7 and Medication Training**

DATE SURVEY 10/20/2015

Y 050 NAC 449.194(1) Administrator's.

Based on observation, interview and record review, the Administrator failed to provide oversight and supervision to the staff; failed to ensure staff completed the required training ; failed to ensure residents' safety; and failed to ensure residents received needed services. (See TAGs Y0070, Y0072, Y0103, Y0105, Y255, Y0450, Y0859, Y0871, Y0876, Y0878, Y0885, Y0895, Y0905, Y0923, Y936, Y0955, and Y1001).

Severity:2 Scope:3

Y 070 NAC 449.196(1)(f) Qualifications of Caregiver-8 hours.

Based on record review, the facility failed to ensure 4 of 11 employees completed the required annual caregiver training (Employee #2, Employee #5, Employee #8, and Employee #10).

On 10/19/15 in the afternoon, a review of employee files revealed the following:

-Employee #2 was hired on 10/18/14. There was no documented evidence that eight hours of annual caregiver training had been completed.

-Employee #5 was hired on 8/20/14. There was no documented evidence that eight hours of annual caregiver training had been completed.

-Employee #8 was hired on 10/14/14. There was no documented evidence that eight hours of annual caregiver training had been completed.

-Employee #10 was hired on 10/08/14. There was no documented evidence that eight hours of annual caregiver training had been completed.

On 10/19/15 in the afternoon, Employee #5, the Administrator designee acknowledged the deficiency.

Severity: 2 Scope: 2

Y 072 NAC 449.196(3)(a-c) Qualifications of Caregiver-Med

Based on record review and interview, the facility failed to ensure 1 of 11 employees completed the required annual medication management training (Employee #2).

On 10/19/15 in the afternoon a review of employee files revealed:

-Employee #2 was hired on 10/18/14. The employee completed the initial medication management training on 10/16/14 for 16 hours. The employee's file lacked documented evidence of the eight hour annual medication management in 2015.

On 10/19/15 in the afternoon, Employee #5, the Administrator designee acknowledged the deficiency.

Severity:2 Scope: 1

Y 103 NAC 449.200(1)(d) Personnel File - NAC 441A /.Tuberculosis

Based on record review and interview, the facility failed to ensure 3 of 11 employees met the requirements concerning tuberculosis (TB) and pre-employment physical examinations (Employee #1, #4, and #10).

On 10/19/15 in the afternoon, a review of employee files revealed the following:

- Employee #1 was hired 2/18/15. The employee file had a two-step TB test with a final read date of 1/30/14, over one year prior to hire. The file lacked a TB test for 2015.

- Employee #4 was hired on 9/10/15. The employee file had a single TB test with a read date of 10/15/15, after the date of hire. The file lacked documented evidence of a pre-employment physical examination and a second TB test.

- Employee #10 was hired on 10/8/14. The employee file lacked documented evidence of a pre-employment physical examination.

On 10/19/15 in the afternoon, Employee #5, the Administrator designee acknowledged the deficiency.

Severity: 2 Scope: 2

Y 105 NAC 449.200(1)(f) Personnel File - Background Check.

Based on record review and interview, the facility failed to ensure 4 of 11 employees met background check requirements (Employee #1, #4, #7, and #11).

On 10/19/15 in the afternoon, a review of employee files revealed the following:

- Employee #1 was hired on 2/18/15. The employee's fingerprints were dated 3/11/15. The employee obtained their fingerprints past their first ten days of employment.

- Employee #4 was hired on 9/10/15. The employee's fingerprints were dated 10/12/15. The employee obtained their fingerprints past their first ten days of employment.

- Employee #7 was hired on 8/5/15. The employee's fingerprints were dated 8/21/15. The employee obtained their fingerprints past their first ten days of employment.

- Employee #11 was hired on 2/17/15. The employee's fingerprints were dated 3/16/15. The employee obtained their fingerprints past their first ten days of employment.

On 10/19/15 in the afternoon, Employee #5, the Administrator designee acknowledged the deficiency.

Severity: 2 Scope: 2

Y 255 NAC449.217(6)(a)(b) Permits - Comply with NAC 446 On Food

Based on observation on 10/20/15, the facility failed to ensure the kitchen complied with the standards of NAC 446.
1. Critical Violations:

a. At the time of inspection, the Person in Charge, was not certified in food safety.

2. Major Violations:

a. Bins of oats, flour, and sugar were stored on the floor in the dry storage room.

b. The following food contact surfaces were not commercial grade: crock-pot, can opener, blender, and plastic bins that were storing ready to eat foods.

c. The following non-food contact surfaces were not commercial grade: resident refrigerator and freezer.

Severity: 2 Scope: 2

Y 431 NAC 449.229(2) State Fire Marshall referral.

Based on record review and interview, the facility failed to ensure smoke detector checks

and fire drills were conducted monthly. - State Fire Marshall Referral.

On 10/20/15 in the morning, a review of the smoke detector test log revealed a lack of documentation smoke detectors were tested for the past 12 months.

On 10/20/15 in the morning, a review of the fire drill logs revealed a lack of documentation fire drills were performed in March and May of 2015.

On 10/20/15 in the morning, Employee #5, the Administrator Designee acknowledged the missing documentation.

Y 450 NAC449.231(1) First Aid and CPR.

Based on record review and interview, the facility failed to ensure 3 of 11 employees completed the training on cardiopulmonary resuscitation (CPR) and first aid (FA) (Employees #1, #7 and #10).

On 10/19/15 in the afternoon, a review of employee files revealed:

- Employee #1 was hired 2/18/15. There was no documented evidence the employee completed the required CPR/FA training.

- Employee #7 was hired 8/5/15. There was no documented evidence the employee completed the required CPR/FA training.

- Employee #10 was hired 10/18/14. The CPR/FA card on file expired 12/2014. The current CPR/FA card on file was issued on 9/30/15 by an on-line company. The file lacked documented evidence the employee had received hands-on CPR training and was completed nine months after the previous card had expired.

On 10/19/15 in the afternoon, Employee #5, the Administrator designee, acknowledged the deficiencies.

Severity:2 Scope: 2

Y 859 NAC 449.274(5) Periodic Physical examination of aResident

Based on record review and interview, the facility failed to ensure 9 of 13 residents received a valid pre-admission physical examination (Residents #2, #3, #4, #5, #6, #7, #8, #9, #11).

Findings include:

On 10/20/15 in the morning, a review of resident files revealed the following:

-Resident #2 was admitted on 2/28/15. The pre-admission physical conducted on 2/9/15 lacked documented evidence of assessment for cognitive safety, resident care plan and physician assessment forms were signed but not completed.

-Resident #3 was admitted on 3/4/15. The pre-admission physical conducted on 3/2/15 lacked documented evidence of assessment for cognitive safety and category I or II designation.

-Resident #4 was admitted on 3/20/15.The pre-admission physical conducted on 3/9/15 lacked documented evidence of assessment for cognitive safety, category I or II designation and physician assessment forms were signed but not completed.

-Resident #5 was admitted on 3/20/15. The resident obtained a physical on 3/30/15, ten days after the date of admission, The physical lacked documented evidence of assessment for cognitive safety, category I or II designation and physician assessment forms were signed but not completed.

-Resident #6 was admitted on 6/18/15. The pre-admission physical conducted on 6/12/15. The physician assessment forms were signed but not completed.

-Resident #7 was admitted on 6/23/15. The pre-admission physical conducted on 5/12/15 lacked documented evidence of assessment for category I or II designation.

-Resident #8 was admitted on 6/13/15. The pre-admission physical conducted on 5/18/15 lacked documented evidence of assessment for category I or II designation.

-Resident #9 was admitted on 6/23/15. The resident obtained a physical on 6/25/15, two days after the date of admission, The physical lacked documented evidence of assessment for category I or II designation.

-Resident #11 was admitted on 5/2/15. The pre-admission physical conducted on 4/27/15 lacked documented evidence of assessment for category I or II designation.

On 10/20/15 in the afternoon, Employee #5, the Administrator designee acknowledged the incomplete and missing physical examination documentation.

Severity: 2 Scope 3

Y 871 NAC 449.2742(1)(d)(1-8)(1)(e) Medication Plan.

Based on record review and interview, the Administrator failed to ensure the facility's policies and procedures regarding medication management were followed by staff.

See TAGs Y0878, Y0890, Y0895, Y0905 and Y0923.

Severity: 2 Scope: 3

Y 876 NAC449.2742(4) Medication Administration NRS. 449.037

Based on record review, interview and observation, the facility failed to ensure an ultimate user agreement was on file for 13 of 13 residents (Residents #1- #13).

On 10/20/15 in the morning, a review of the resident files revealed all files lacked documented evidence of an ultimate user agreement. The residents' medications were observed in the facility's medication cart and documented in the facility's Medication Administration Record (MAR) indicating the facility possessed and administered the residents medications.

On 10/20/15 in the morning, Employee #5, the Administrator designee acknowledged the findings and reported the Administrator was developing an ultimate user agreement form but had not done so yet.

Severity:2 Scope:3

Y878 NAC 449.2742(5)(6) Medication / OTCs,

Based on observation, record review and interview, the facility failed to ensure 12 of 13 residents received medications according to physician's instructions (Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12 and #13)

Resident #1 was admitted on 5/27/15 with diagnosis of brittle bones.

- The resident's medication cart included Nystop Powder 100,000 U-C Powder, apply to affected area twice a day; however, this medication was not listed on the MAR. The doctor's order dated 10/23/15 changed this medication from routine to PRN. There was no documented evidence the medication was administered as labeled or if it was not administered at all.

Resident #2 was admitted on 2/28/15 with diagnoses including diabetes mellitus type 2, osteoporosis, degenerative joint disease (DJD) and hypothyroidism.

- Review of October 2015 MAR listed Clotrimazole topical 1%, apply to affected areas twice daily, was administered at 8:00 AM and 8:00 PM. A doctor's order dated 10/22/15 instructed Clotrimazole topical 1%, apply to affected areas twice daily as needed. The medication was not onsite.

- The October 2015 MAR listed Tylenol 500 mg, take one tablet as needed for pain not to exceed three in a twenty-four hour period. The doctor's order dated 10/22/15 instructed Tylenol 500 mg, take one tablet as needed for pain not to exceed three in twenty-four hour period. The medication was not onsite.

Resident #3 was admitted on 3/4/15 with diagnoses including left hip fracture, anxiety/depression and hypothyroidism.

- The October 2015 MAR listed Tylenol 500 mg, take two tablets by mouth every six hours not to exceed six in twenty-four hours. The doctor's order dated 10/23/15 prescribed Tylenol 500 mg, take two tablets by mouth every six hours not to exceed six in twenty-four hours as needed for pain. The medication was not onsite.

The MAR listed Aspirin 325 mg, take one tablet every twelve hours not to exceed two in twenty-four hours. The doctor's order dated 10/23/15 prescribed Aspirin 325 mg, take one tablet every twelve hours not to exceed two in twenty-four hours as needed for pain. The medication was not onsite.

Resident #5 was admitted on 3/20/15 with diagnoses including coronary arteriosclerosis, congestive heart failure and chronic obstructive pulmonary disease.

- The October 2015 MAR listed Furosemide 80 mg, take one tablet by mouth daily for

congestive heart failure. The medication was labeled Furosemide 40 mg, take one tablet by mouth twice daily. The doctor's order dated 10/23/15 prescribed Furosemide 40 mg, take 1/2 tablet twice daily for congestive heart failure.

- The October 2015 MAR did not include Klor-Con M20. However, the resident's medication cart included Klor-Con M20, take one tablet by mouth daily. The doctor's order dated 10/23/15 prescribed Klor-Con M20, take one tablet by mouth daily. There was no documented evidence this medication was administered.

- The October 2015 MAR listed Metoprolol Succinate ER 25 mg, take one half tablet everyday by mouth in the morning for heart. The medication was labeled Metoprolol Succinate 50 mg, take one tablet by mouth daily. There was a note on the doctor's order sheet that read: "Metoprolol Succinate ER 25 mg. Our facility pharmacist had me take these back down to Smith's and he repacked them as 1/2 tablet with labels that read - Directions Changed Refer to Chart, on each one until they are gone then the doctor will prescribe the right dosage. There was no doctor's order to specify the correct strength and dosage.

- On 10/16/15, the doctor ordered to hold Aspirin and restart on 10/18/15. The October 2015 MAR documented the resident was administered Aspirin 81 mg, take one tablet daily for heart on 10/16/15 and 10/17/15.

- On 10/18/15, the doctor ordered put Triple Antibiotic ointment in bilateral nostrils three times per day for seven days. There was no documented evidence this medication was administered from 10/18/15 to 10/20/15, the survey date.

Resident #6 was admitted on 6/18/15, with diagnoses including diabetes mellitus type II and asthenia.

- The October 2015 MAR listed Tylenol 500 mg, take one tablet by mouth every six hours not to exceed four in twenty four hours. The doctor's order dated 9/30/15 included Tylenol, strength unspecified, one tablet every six hours not to exceed four in twenty four hours. There was no documentation on MAR that the medication was administered. The medication was not onsite.

Resident #7 was admitted on 6/23/15, with diagnoses including malignant neoplastic disease, anemia and osteoporosis.

- Review of October 2015 MAR revealed the following medications were listed:

Tums 500 mg, take one tablet every four hours as needed to not exceed ten in twenty four hours. There was no doctor's order available for review. The medication was not onsite.

Tylenol 500 mg, take one tablet by mouth every four hours not to exceed six in twenty four hours. There was no doctor's order available for review. The medication was not onsite

Levaquin 500 mg, take one tablet by mouth daily for infection control. The medication was administered on 10/3/15 and 10/4/15, but not administered the rest of October 2015. There was no doctor's order available for review, so that it was not determined if Levaquin 500 mg was discontinued. The medication was not on site.

Resident #8 was admitted on 6/13/15 with diagnoses including hypertension and chronic pain syndrome.

- Review of October 2015 MAR listed Mild of Magnesia, take 30 milliliters (ml) daily as needed. The doctor's order listed on Charting for 5/1/15 to 5/31/15 included Milk of Magnesia 400 mg/5ml, take 30 ml by mouth everyday as needed for constipation, hold for loose stools. The medication was not onsite.

Morphine Sulfate ER 30 mg per twelve hours, take one tablet by mouth daily was administered at 8:00 AM from 10/1/15 to 10/8/15 and at 4:30 PM from 10/9/15 to 10/19/15. The doctor's order listed on Charting for 5/1/15 to 5/31/15 included Morphine Sulfate ET 30 mg, take one tablet by mouth twice daily at 8:00 AM and 8:00 PM.

Resident #9 was admitted on 6/23/15 with diagnoses including atrial fibrillation, hypertension, hypothyroidism and cachexia syndrome.

- Review of October 2015 MAR listed Phillips Stool Softener Sodium 100 mg, take two caplets by mouth at bedtime for constipation. It was documented as PRN (as needed) in the column for time of administration. This medication was administered as PRN. On 10/23/15, the physician provided an order for Phillips Stool Softener Sodium 100 mg, take two caplets at bedtime for constipation. On 10/20/15 at 2:30, the House Manager indicated they will change the instructions in the MAR. On 10/20/15 at 2:35 PM, the physician's medical assistant indicated Phillips Stool Softener Sodium 100 mg was supposed to be daily.

Resident #10 was admitted on 7/23/15 with diagnoses including hypertension, chronic obstructive pulmonary disease, cirrhosis and anemia.

- The resident's medication cart included Ondansetron ODT 4 mg tablet, dissolve one to two tablets by mouth every six to eight hours as needed for nausea. The medication had expired in January 2015. A doctor's order dated 10/22/15 specified Ondansetron 4 mg, take one tablet by mouth every eight hours as needed for nausea. The new medication was not onsite.

Resident #11 was admitted on 5/2/15 with diagnoses including anemia and chronic kidney disease stage III.

- Review of October 2015 MAR revealed Lisinopril 20 mg, take one tablet by mouth daily. The medication was labeled Lisinopril/HCTZ 20-12.5 mg, take one tablet by mouth once daily. There was no doctor's order available for review.

Resident #12 was admitted on 9/1/15 with diagnoses including progressive supranuclear palsy, hypertension and diabetes mellitus type II.

- Review of October 2015 MAR revealed Gold Bond Maximum Strength 1%, apply to affected area as needed. There was no doctor's order available for review to determine if the medication was discontinued. The medication was not onsite.

Neosporin 400 units, administered to area as needed. There was no doctor's order available for review to determine if the medication was discontinued. The medication was not onsite.

Flexeril/cyclobenzaprine (muscle relaxant) 10 mg, take one tablet by mouth as needed for pain. The MAR noted this medication as PRN and was not administered from 10/1/15 to 10/20/15. The medication bottle was labeled cyclobenzaprine 10 mg, take one tablet by mouth three times a day. The resident's Medication History dated 10/22/15, included cyclobenzaprine 10 mg tablet, but did not specify the frequency of administration.

Erythromycin Ophthalmic 0.5%, apply one drop in eyes as needed. The MAR documented the medication was administered on 10/4/15 only. The medication was labeled Erythromycin Ophthalmic 0.5%, apply one ribbon two times a day in each eye for seven days. The resident's Medication History dated 10/22/15, included Erythromycin 5 mg/gram (0.5%) eye ointment, but did not specify the frequency of administration.

The resident's medication cart included Hydrocodone/Acetaminophen 10-325 mg, take one-half to one tablet by mouth every six hours as needed for pain. This medication was not on the MAR. The resident's Medication History dated 10/22/15 included Hydrocodone 10 mg acetaminophen 325 mg tablet, but did not specify the dosage and frequency of administration.

Atorvastatin Calcium 10 mg, take one tablet by mouth daily for cholesterol. The medication bottle was also labeled Atorvastatin Calcium 10 mg,
take one tablet by mouth daily for cholesterol. However, the resident's Medication History dated 10/22/15 included Lipitor (brand name for atorvastatin) 40 mg, take one tablet every day by oral route at bedtime for 90 days. It was prescribed on 9/8/15.

The resident's Medication History dated 10/22/15 included mupirocin 2% topical ointment, apply a small amount to affected area by topical route three time per day. It was prescribed on 7/29/15. The October 2015 MAR did not include this medication. There was no doctor's order to discontinue this medication. The medication was not onsite.

Oxybutinin Chloride 5 mg, take one tablet by mouth twice daily for bladder. The resident's Medication History dated 10/22/15 included Oxybutinin chloride 5 mg, take one tablet twice a day by oral route. This medication was administered at 7:30 AM from 10/1/15 through 10/5/15, and at 8:30 AM from 10/6/15 through 10/20/15. This

medication was not administered in the afternoon or evening.

The resident's Medication History dated 10/22/15 included ToletrodineER 4 mg capsule, extended release 24 hours, but did not specify frequency of dosing. This medication was filled on 9/1/15. This medication was not on the October 2015 MAR and was not available onsite.

The resident's Medication History dated 10/22/15 included Vesicare 10 mg tablet, but did not specify frequency of dosing. This medication was filled on 7/25/15. There was no doctor's order to discontinue Vesicare 10 mg. This medication was not on the October 2015 MAR and was not
Resident #13 was admitted on 2/28/15 with diagnoses including neck injury, hypertension, glaucoma and gastroesophageal reflux disease.

- Review of October 2015 MAR revealed Xalatan 0.005% put one drop in left eye at bedtime every other night. This medication was administered every other night from 10/2/15 through 10/18/15. The medication was labeled Xalatan 0.005% put one drop in the left eye once daily every night. It was filled on 10/1/15. The doctor's order dated 10/22/15 included Xalatan 0.005%, put one drop in left eye once daily in the evening.

- On 10/20/15, in the afternoon, the House Manager acknowledge all findings and indicated they will obtain current list of medications from the residents' physician.

Severity:2 Scope: 3

Y 895 NAC 449.2744(1)(b 1-4)+449.2746(2) Medication / MAR-PRN MAR

Based on record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate, matched the doctor's order and medication label for 8 of 13 residents (Residents #1, #3, #5, #7, #8, #10, #12, 13.

- Resident #1 - Review of October 2015 MAR revealed:

Oxycodone Hcl 5 mg (milligram), take one to two tablets by mouth every four hours as needed for pain. The medication was not onsite. Additional information dated 10/23/15 included a doctor's order to discontinue this medication.

Acetaminophen-Oxycodone 325 mg - 5 mg, take one to two tablets by mouth every six hours as needed for pain. The medication label read Acetaminophen-Oxycodone 325 mg - 5 mg, take one to two tablets by mouth every four to six hours as needed.

Vitamin D2 50,000 International Units, take one capsule weekly for three months. The medication was labeled Vitamin D3 5,000 IU, take one capsule weekly for three months. The medication labeled Nystop Powder 100,000 U-C Powder, apply to affected area twice a day, was not on the MAR. The doctor's order dated 10/23/15 changed the administration from routine to "as needed" (PRN).

- Resident #3 - Review of October 2015 MAR revealed:

Vitamin D3 1000 International Units (IU), take one capsule daily for intestinal absorption. The medication was labeled Vitamin D3 2000 IU, take one capsule daily for intestinal absorption. The doctor's order dated 10/23/15 prescribed Vitamin D3 2000 IU, take one capsule daily for intestinal absorption.

- Resident #5 - Review of October 2015 MAR revealed:

Lido Cream 2%, apply to buttocks every four to six hours for pain. On 10/23/15, the doctor ordered to discontinue this medication.

- Resident #7 - Review of October 2015 MAR revealed:

Calcium 600 mg, take one tablet by mouth daily. The MAR documented the medication was administered once daily at 8:00 AM. The medication was labeled Calcium 600 mg, take one tablet by mouth twice daily. There was no doctor's order available for review to verify the frequency of dose.

Tramadol 50 mg, take one tablet every six hours as needed for pain. The medication was labeled Tramadol 50 mg, take one-half to one tablet by mouth every six hours as needed for pain. There was no doctor's order available for review to determine the correct dose.

The medication labeled
Oxycodone/Acetaminophen 5-325 mg, take one tablet every eight hours as needed, was not included in the MAR. There was no doctor's order to determine if this medication was discontinued.

- Resident #8 - Review of October 2015 MAR revealed:

Ondansetron 4 mg, take one tablet by mouth every four hours as needed for nausea. The medication was labeled as Ondansetron 4 mg, take one tablet by mouth three times daily as needed. The doctor's order listed on Charting from 5/1/15 to 5/31/15 included Ondansetron 4 mg, take one tablet by mouth every four hours as needed for nausea or vomiting. The Physician's Order (undated) noted for Ondansetron ODT 4 mg to put a change label on prescription that read: "Directions changed, refer to chart."

- Resident #10 - Review of October 2015 MAR revealed:

Furosemide 20 mg, take one-half tablet by mouth every other day in the AM for edema.

The medication was labeled as Furosemide 20 mg, take one to two tablets by mouth every other day in the AM for edema. The doctor's order dated 10/8/15 specified Furosemide 20 mg, take one-half tablet by mouth every other day in the AM for edema.

- Resident #12 - Review of October 2015 MAR revealed:

Alphagan 0.2%, put one drop in eyes two times daily. The medication was labeled Alphagan 0.1%, put one drop in eyes two times daily. The physician's order dated 10/23/15 included Alphagan 0.1% put one drop in eyes two times daily.

- Resident #13 - Review of October 2015 MAR revealed:

- Review of October 2015 MAR revealed Temazepam 15 mg, take one tablet before bedtime for sleep. The medication was labeled Temazepam 15 mg, take one to two capsules by mouth at bedtime as needed for sleep. The physician's order dated 10/22/15, included
temazepam 15 mg, take one capsule by mouth at bedtime for sleep.

Levothyroxine Sodium (Eltroxin) 75 microgram (mcg), take one and a half tablets daily for thyroid. The medication was labeled Eltroxin 50 mcg, take one and one-half tablets daily. The doctor's order dated 10/22/15 included Levothyroxine Sodium (Eltroxin) 50 mcg, take one and one-half tablets daily for thyroid.

- On 10/20/15, in the afternoon, the House Manager explained the facility's electronic MAR could document the reason for PRN administration but not the result or outcome.

- On 10/20/15, the House Manager

acknowledged the findings and obtained a list of current medications from the residents' physician.

Severity:1 Scope: 3

Y 905 NAC 449.2746(1)(a)-(c) PRN Medication.

Based on record review and interview, the facility failed to ensure the doctor's order for "as needed" medications included specific amount and frequency of administration for 4 of 13 residents (Residents #1, #3, #11, and #13)

- Resident #1 was admitted on 5/27/15 with diagnosis of brittle bones.

The October 2015 Medication Administration Record (MAR) listed Acetaminophen-Oxycodone 325 mg (milligram) - 5 mg, take one to two tablets by mouth every six hours as needed for pain.

The medication label read Acetaminophen-Oxycodone 325 mg - 5 mg, take one to two tablets by mouth every four to six hours as needed for pain.

The doctor's order dated 10/23/15 was for Acetaminophen-Oxycodone 325 mg - 5 mg, take one to two tablets by mouth every four to six hours as needed for pain.

- Resident #3 was admitted on 3/4/15 with
diagnoses including left hip fracture, anxiety/depression and hypothyroidism.

The doctor's order dated 10/1/15 prescribed Oxycodone-Acetaminophen 10-325 mg, take one tablet by oral route every eight to twelve hours as needed for pain, maximum three a day.

- Resident #11 was admitted on 5/2/15 with diagnoses including anemia and chronic kidney disease stage 3.

Review of October 2015 MAR revealed Oxycodone Hydrochloride 5 mg, take one-half to one tablet by mouth every six hours as needed for pain for 30 days. The physician's order dated 10/23/15 included Oxycodone 5 mg, take one-half to one tablet by mouth every six hours as needed for pain for 30 days.

- Resident #13 was admitted on 2/28/15 with diagnoses including neck injury, hypertension, glaucoma and gastroesophageal reflux disease.

Review of October 2015 MAR revealed Temazepam 15 mg, take one tablet before bedtime for sleep. The medication was labeled Temazepam 15 mg, take one to two capsules by mouth at bedtime as needed for sleep. The physician's order dated 10/22/15, included Temazepam 15 mg, take one capsule by mouth at bedtime for sleep.

On 10/20/15, in the afternoon, the House Manager acknowledged the findings and indicated thewill obtain a list of current medications from the residents' physician.

Severity:2 Scope: 2

Y 923 NAC 449.2748(3)(a-b) Medication Container.

Based on record review, observation and interview, the facility failed to ensure prescription medications were labeled by a pharmacist and over-the-counter medications were labeled with the resident's name and prescribing physician's name for 4 of 13 residents (Resident #2, #3, #6 and #13)

- The resident's medication cart included Nystatin-Triamcinolone 100,000 units/gram 0/1%, apply to affected areas twice a day as needed . The tube did not have the resident's

name and the prescribing physician.

The resident's medication cart included Celebrex 200 mg, a prescription medication. This medication box was hand labeled with instructions to take one capsule twice daily with food for joint pain. The back of medication box listed the manufacturer as a company in Australia. For medical information, the package provided phone numbers in Australia and New Zealand.

Resident #3:

- The resident's medication cart included Miralax 17 grams, take 17 grams everyday by oral route for 30 days. The container did not have the resident's name or prescribing physician. There was no doctor's order available for review.

Resident #6:

- The resident's medication cart included Tradjenta 5 mg, take one tablet by mouth daily for diabetes. The container did not have the resident's name or prescribing physician. The resident's Medication Profile dated 9/30/15 included Tradjenta oral 5 mg daily. On 10/29/15 at 4:25 PM, the House Manager indicated it was a sample from resident's doctor.

Resident #13:

- The resident's medication cart included Carvedilol 25 mg, a prescription medication. This medication box had a white 2 adhesive label hand labeled with instructions to" take one tablet by mouth twice daily for heart and blood pressure." The back of medication box listed the manufacturer as a company in India.

On one side of the box, there was a label that read: "Schedule H drug Warning: To be sold by retail on the prescription of a Registered Medical Practitioner only."

On 10/20/15, the House Manager the House Manager provided empty boxes of the medications manufactured in Australia and India . The House Manager indicated Residents #2 and #13, who were a couple, wanted to mitigate the cost of medications so they decided to order online from the above foreign countries.

Severity:2 Scope: 2

Y 936 449.2749(1) (e) Resident file-NRS 441A.

Tuberculosis

Based on record review and interview, the facility failed to ensure 12 of 13 residents met the
requirements concerning tuberculosis (TB) (Residents #1, #2#4, #5, #6, #7, #8, #9, #10, # 11, #12 and #13).

On 10/20/15 in the morning, a review of resident files revealed the following:

- Resident #1 was admitted on 5/27/15. The resident's file contained evidence of a single step TB test completed on 5/24/15 with a negative result. There was no documented evidence a second TB test was completed.

- Resident #2 was admitted on 2/28/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #4 was admitted on 3/20/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #5 was admitted on 3/20/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #6 was admitted on 6/18/15. The resident's file contained evidence of a single step TB test completed on 6/17/15 with a negative result. There was no documented evidence a second TB test was completed.

- Resident #7 was admitted on 6/23/15. The
resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #8 was admitted on 6/13/15. The resident's file contained evidence of a single step TB test completed on 11/12/14 with a negative result. There was no documented evidence a second TB test was completed.

- Resident #9 was admitted on 6/2315. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #10 was admitted on 7/23/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #11 was admitted on 5/2/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #12 was admitted on 9/1/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

- Resident #13 was admitted on 2/28/15. The resident was missing documented evidence a signs and symptoms evaluation was completed upon admission and there was no TB test found in the resident's file.

On 10/20/15 in the morning, Employee #5, the Administrator designee acknowledged the deficiency.

Severity: 2 Scope: 3

Y955 NAC 449.2751 Assisted Living Endorsement

Based on record review and interview, the facility was using the words "assisted living" in their resident agreement without an endorsement for 13 of 13 residents.

On 10/20/15 in the morning, a review of resident records revealed the resident admission packet had multiple references to the facility being assisted living, including the following statement from the admission policy: "Bee Hive Homes is an assisted living facility licensed to care for elderly resident(s) in a home like environment."

On 10/20/15 in the morning, Employee #5, the Administrator designee acknowledged the findings and reported the Administrator was rewriting the packet to exclude the assisted living terminology but had not done so yet.

Severity: 1 Scope: 3

Y1001 NAC 449.2758(1) Training Req-Elderly Disabled

Based on record review and interview, the facility failed to ensure that a minimum of 4 hours of training related to the care of elderly and disabled residents was received within 60 days of hire for 9 of 9 caregivers

(Employee #1, #2, #3, #5, #6, #7, #8, #9, and #10).

On 10/19/15 a review of employee files revealed the following:

- Employee #1 was hired on 2/18/15. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #2 was hired on 10/18/14. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #3 was hired on 4/7/15. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #5 was hired on 8/20/14. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #6 was hired on 6/1/15. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #7 was hired on 8/5/15. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #8 was hired on 10/14/14. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #9 was hired on 5/29/15. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

- Employee #10 was hired on 10/8/14. The employee file lacked documented evidence four hours of training related to the care of elderly and disabled residents had been completed.

On 10/19/15 in the afternoon, Employee # 5, the Administrator designee, reported they were unaware of the initial training requirement and was unable to provide documented evidence of the training.

Severity: 2 Scope:3

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**4/13/2016**
Case No.:	**B-36137**
Administrator:	**Marilou Reyes**
License No.	**RFA 9231**
Admin of Record:	**7/7/09 to present**
Referral from:	**DPBH**
Survey Date:	**1/19/2016**
Survey due to:	**Annual State Licensure Survey**
Facility:	**Little Angel Care Home** **1436 Heaven Drive** **Sparks 89436**
Number of Beds:	**5**

PROPOSED DISCIPLINE

Fine:	$ **700.00**
Admin Cost:	**375.00**
Training Cost:	**100.00**
Training:	**Best Practices Modules 1 and 4**

Y 074 NRS 449.093 Elder Abuse Training

Employee #5 was hired as a caregiver on 3/1/15. On 1/19/16 in the afternoon, a review of the employee's file lacked documented evidence of elder abuse prevention training.

On 1/19/16 in the afternoon, Employee #3 acknowledged the findings.

Severity: 2 Scope: 1

Y 103 NAC 449.200(1) (d) Personnel File - NAC 441A /

Based on record review and interview, the facility failed to ensure 2 of 5 employees complied with tuberculosis (TB testing and pre-employment physical examinations (Employee #4 and #5)

Employee #4 was hired as a caregiver on 9/8/15. On 1/19/16 in the afternoon, a review of the employee's file revealed a negative second step TB test dated 8/2/13. However, the file lacked documented evidence of 2014 and 2015 annual TB tests.

Employee #5 was hired as a caregiver on 3/1/15. On 1/19/16 in the afternoon, a review of the employee's file revealed a positive TB test dated 11/12/13 and a cleared chest X-ray dated 11/15/13. However, the file lacked documented evidence of signs and symptoms for 2015. Additionally, the file lacked documented evidence of a pre-employment physical.

On 1/19/16 in the afternoon, Employee #3 acknowledged the missing documents.

Severity: 2 Scope: 2

Y 105 NAC 449.200(1) (f) Personnel File - Background Check

Based on record review and interview, the facility failed to ensure 2 of 5 employees met background check requirements of NRS 449 (Employee #4 and #5).

Employee #4 was hired as a caregiver on 9/8/15. On 1/19/16 in the afternoon, a review of the employee's file revealed fingerprints were submitted on 7/2/13. The State clearance report was under another facility's account and the file lacked documented evidence of the FBI clearance report.

Employee #5 was hired as a caregiver on 3/1/15. On 1/19/16 in the afternoon, a review of the employee's file lacked documented evidence of a criminal history statement, a fingerprint submission form and a background clearance report.

On 1/19/16 in the afternoon, Employee #2 and #3 acknowledged the missing documents.

Severity: 2 Scope: 2

Y 859 NAC 449.274(5) Periodic Physical examination of a resident

Based on record review and interview, the facility failed to ensure 1 of 4 residents received a valid or timely pre-admission physical examination (Residents #4).

.

Resident #4 was admitted on 9/7/15. On 1/19/16 in the afternoon, a review of the file revealed the resident obtained a physical on 10/28/15, which was more than seven weeks after the date of admission.

On 1/19/16 in the afternoon, Employee #2 and #3 acknowledged the findings.

Severity: 2 Scope: 2

Y 936 NAC 449.2749(1) (e) Resident file-NRS 441A .

Based on record review and interview, the facility failed to ensure 1 of 4 residents met the requirements concerning tuberculosis (TB) testing (Residents #1).

Resident #1 was admitted on 11/13/10. On 1/19/16 in the afternoon, a review of the resident file revealed an annual TB test was read as negative on 11/19/14. However the 2015 annual TB test was not read as negative until 12/9/15, which was more than two weeks late.

On 1/19/16 in the afternoon, Employee #3 acknowledged the findings.

Severity: 2 Scope: 2

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**4/13/2016**
Case No.:	**B-36138**
Administrator:	**Sandy R. Hicks**
License No.	**RFA 9382**
Admin of Record:	**1/14/15 to present**
Referral from:	**DPBH**
Survey Date:	**2/26/2016**
Survey due to:	**Complaint Invesigation**
Facility:	**The Homestead** **365 A Street** **Fallon 89406**
Number of Beds:	**53**

PROPOSED DISCIPLINE

Fine:	$ **8,000.00**
Admin Cost:	**375.00**
Training Cost:	
Training:	

DATE OF SURVEY 2/26/2016

Y 503 NAC 449.258(4) Employee Compliance with Written Polices

Based on observation, document review and interview, the facility failed to ensure compliance with its infection control policies and procedures.

On 2/16/16, caregivers were observed providing care to residents without the use of gloves, alcohol-based hand sanitizer, nor hand washing between . Additionally, the surveyors observed a common restroom lacked paper towels for approximately four hours and a hand sanitizer was empty for the duration of the inspection, approximately six hours.

A review of the facility's policy, Preventing Transmission of Infection (undated) revealed: - Policy: the transmission of infection is limited by implemented effective interventions.

- Procedure:

1. Hand washing is the most important infection control in the Community.

2(b). Standard precautions involve the use of protective barriers such as gloves, gowns, aprons, masks, and protective eyewear, all of which can reduce the risk of exposure of the skin and mucous membranes to potentially infective materials.

On 2/16/16 in the afternoon, the Interim Administrator communicated she completes routine spot checks to verify employees follow the infection control procedures. She acknowledged the findings.

Severity:2 Scope:3

Y590 NAC 449.268(1)(a) Resident Rights

Based on record review and interview, the Administrator failed to ensure 1 of 48 residents was not neglected or left in an incontinent pad for extended periods (Resident #3).

On 2/16/16, a review of Resident #3's file revealed the following:

- Resident #3 was admitted to the facility on 4/13/15 with primary diagnoses of atrial fibrillation, hypertension and rhabdomyolysis.

- The facility's plan for Resident #3 documented the resident was to receive assistance with bathing one to three times per week; and assistance with transfers and ambulation.

- The facility's log for activities of daily living (ADL) assistance documented the resident only received bathing assistance one time (8/10/15) between a period of thirty one days (8/1/15 8/31/15). The resident received bathing assistance two times (11/22/15 and 12/3/15) between a period of ten days (11/23/15 - 12/3/15). The facility's ADL log also documented on 12/1/15, the resident complained of weakness and needs two people to assist standing. Additionally, the facility's ADL log documented the resident complained he was too weak to stand on 12/2/15.

- Review of a Nevada Department of Health Care Financing and Policy (DHCFP) Serious Occurrence Report dated 10/2/15 indicated Resident #3 was transferred to a local hospital with a chief complaint of pain. The location of the pain was listed as, "pain on his bottom." The resident services director reported, the hospital transferred the resident to the local VA hospital due to pneumonia and returned back to the facility on 10/5/15.

- Review of medication technician's charting note dated 10/12/15 documented Resident #3 still had a big pressure sore on butt. The resident's file lacked documented evidence the resident was sent to a doctor for an assessment.

- Review of a Nevada DHCFP Serious

Occurrence Report dated 12/3/15 indicated Resident #3 was transferred to a local hospital due to not feeling well for a few days and being very weak.

-Review of Emergency Department (ED) Pertinent Report dated 12/3/15 documented, the resident was not seen for 3 days and was found lying in a chair, incontinent and too weak to move. On Emergency Medical Services (EMS) arrival patient was hypotensive and slightly tachy. The resident's skin was noted as warm, dry, pink, Stage 1-2 pressure ulcers to sacral/upper buttock area. The patient was found in the emergency room with multiple Systemic Inflammatory Response Syndrome (SIRS) criteria and found with sepsis."

-Review of imaging for a Chest x-ray on 12/3/15 report indicated possible pneumonia.

-Review of a History and Physical Pertinent report dated 12/3/15 documented, the resident was found with significant Systemic Inflammatory Response Syndrome

(SIRS) criteria and septic due to most likely a combination of urinary tract infection and possible pneumonitis.

-Review of patient Care Report from the local hospital dated 12/3/15 indicated, the resident was transferred from the facility to the local hospital where he weighed 320 pounds, his pelvis was described as "Incontinence Present," he had left and right foot edemas, however, was alert and oriented to person, place, time and event. The narrative section of the report documented the following:

- Dispatched to a male with weakness. The resident had been feeling weak and had chills for 1 week.

- The caregivers explained the resident had not been able to get out of his chair for a week. A nurse would come in to check on him and that she nor the caregivers could get him up for the chair. They also recounted the resident had a sore on his buttocks

- Interview with the caregivers also revealed the resident had very little movement from his chair and the padding underneath had a strong odor of ammonia and he was incontinent with brown staining on pad.

- The caregivers said, the resident reported his bottom hurt. The sore on his bottom was examined by the caregiver and was noted to be about 2 inches in circumference and was red and white tinted."

-Review of Discharge Summary Pertinent Report on 12/7/15 indicated the cause of death as septic shock secondary to community-acquired pneumonia and urinary tract infection. The time of death was 10:09 AM.

A review of the facility's Alert Charting Policy and Procedure (undated), revealed the following: - Purpose: To ensure that all residents with a change of condition are assessed and monitored appropriately and that there is documentation in the resident record to reflect the resident's condition.

- Policy: Anytime a resident has a change of condition...alert charting will be initiated. - Procedure: When it is identified that the resident requires closer observation the designated staff will initiate alert charting by: record observations in the resident's care record...inform the resident's physician and/or family as indicated."

On 2/16/16 at 9:13 AM, during an onsite visit to the facility, a strong odor of urine was detected in the hallway near the Chapel.

On 2/16/16 at 9:17 AM, a resident was interviewed and expressed often caregivers get too busy and were not able to provide her with additional bathing and toileting.

On 2/16/16 at 9:28 AM, another resident was interviewed and expressed he waited for assistance for one hour and seventeen minutes, with a minimum response time of 18 minutes. The resident described staff appeared to have a lack of training in how to pick residents up nor hold residents up. He explained, when caregivers were on their lunch break there was only one caregiver for both hallways.

On 2/16/16 at 10:43 AM, an employee described the facility could use more part time staff during the day. The employee explained there was only one caregiver for both hallways and when a caregiver would take their lunch break, it created a longer response time for residents.

On 2/16/16 at 1:27 PM, a caregiver recounted if there is an issue or a change in condition of a resident, they are required to report the findings to the medication technician. The caregiver explained the company policy is for the medication technician to report to the Resident Services Director, who in turn will report to Interim Administrator. The caregiver explained she was unaware what happened exactly after she reported the change of condition for residents or whether it prompted any action. The caregiver described having noticed an ongoing issue with Resident #3 beginning in May 2015. She reported her observations, however did not see any changes in care the resident received.

Severity: 4 Scope: 1

. NAC 449.2756(1)(g) Alzheimer's Facility-Toxic

Based on observation, interview and document review, the facility failed to ensure toxic substances were not accessible to residents.

On 2/16/16 at 1:38 PM, a caregiver in the Memory Care unit informed the surveyors the facility was treated for bed bugs within the past month. The caregiver noted a white powdery substance in the carpet of the bedrooms near the walls and underneath beds, which she explained was used to treat the bed bugs.

A review of pest control invoices from 1/22/16 and 2/5/16 revealed, the observation and treatment of bed bugs in resident room #1, #2, #3, #4, #5 and the television area.

On 2/16/16 at 2:33 PM, the Interim Administrator confirmed the Memory Care unit was treated for bed bugs with a white powdery substance still present.

Severity:2 Scope:3

Y9999 Final Observations

NRS 449.150(2) authorizes the Health Division to conduct an investigation into the qualifications of personnel, methods of operation, policies, procedures and records of that facility.

Based on observation and interview, the facility failed to provide records of the facility.

On 2/16/16 in the morning, the surveyor asked the Interim Administrator to provide occurrence/incident reports from the facility for the past six months. She denied the request and explained corporate advised the facility those reports are intended for internal use only and are no longer allowed to give the reports to the Division.

On 2/16/16 in the afternoon, during the exit conference, this was brought to the attention of the Regional Director of Operations, however the reports were not provided.

Severity:1 Scope: 3

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**4/18/2016**
Case No.:	**B-36139**
Administrator:	**Sandy R. Hicks**
License No.	**RFA 9382**
Admin of Record:	**1/14/15 to present**
Referral from:	**DPBH**
Survey Date:	**12/3/2015**
Survey due to:	**Annual State Licensure Survey & Complaint Invesigation**
Facility:	**The Homestead** **365 A Street** **Fallon 89406**
Number of Beds:	**53**

PROPOSED DISCIPLINE

Fine:	$ **5,000.00**
Admin Cost:	**375.00**
Training Cost:	**100.00**
Training:	**Best Practices Modules 1 & 4 and** **8 hours Medication Training**

Date Survey 12/10/2015

Y 050 NAC 449.194(1) Administrator's.

Based on observation, document review, record review and interview, the Administrator failed to ensure residents received needed services and protective supervision. See TAGs: Y0074, Y0085, Y0103, Y0105, Y0178, Y0255, Y0450, Y0590, Y0783, Y0859, Y0861, Y0878, Y0936, Y0966, Y0991, Y0992, Y1010, Y1035, Y1036 and Y1038.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity:2 Scope: 3

Y 074 NRS 449.093 Elder Abuse Training.

Based on record review and interview, the facility failed to ensure 5 of 11 employees acquired initial or annual elder abuse training prior to providing care to the residents (Employee #3, #4, #6, #10 and #11).

Employee #3 was hired on 10/16/14 and began providing care service to residents on 1/1/15. On 10/1/15 in the morning, review of the employee file revealed elder abuse training dated 2/5/15.

Employee #4 was hired on 9/22/14. On 10/1/15 in the morning, the employee file lacked documented evidence of 2015 elder abuse training. The last documented elder abuse training was dated 9/22/14.

Employee #6 was hired on 3/27/15 and began providing care to residents on 3/30/15. On 10/1/15 in the morning, review of the employee file revealed elder abuse training dated 4/3/15.

Employee #10 was hired on 1/17/15 and began providing care to residents on 2/2/15. On 10/1/15 in the morning, review of the employee file revealed elder abuse training dated 2/5/15.

Employee #11 was hired on 7/8/14. On 10/1/15 in the morning, review of the employee file revealed elder abuse training dated 7/8/14. The employee file lacked documented evidence of 2015 annual elder abuse training.

On 10/1/15 at 12:40 PM, the Interim Executive Director confirmed the deficiencies.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity: 2 Scope 3

Y085 NAC 449.199(1) Staffing-CG on duty all times

Based on document review, observation and interview, the administrator failed to ensure a sufficient number of caregivers were on duty .

The facility Ombudsman from Aging and Disability Services Division (ADSD) reported that during visits on 7/6/15, 8/10/15 and 9/9/15, interviews were conducted with several residents who were alert and oriented. The residents voiced concerns about inadequate staffing at the facility . On 7/6/15, the Interim Director indicated to the ADSD Ombudsman they would request approval for a full time caregiver. On 9/9/15, the Interim Director reported to the ADSD Ombudsman they were not approved for an additional caregiver due to the independence level of many of the residents.

On 10/1/15 at 8:20 AM during a tour of the facility, observed caregivers working as dining room staff serving breakfast to the residents.

Review of the facility's census and staffing schedules revealed:

-Senior Living:

February 2015 - Census = 38 residents. Two caregivers and one medication technician per shift.

March 2015 - Census = 39 residents. One day caregiver on 3/6/15 and 3/25/15. Day shift = 5:45 AM - 1:00 PM. One evening caregiver on 3/3/15, 3/4/15, 3/7/15, 3/8/15, 3/14/15, 3/15/15 and 3/18/15. Evening shift = 1:30 PM - 9:30 PM.

-Memory Care:

February 2015 - Census = 10 residents. No night shift caregivers between 2/1/15 - 2/28/15. Night shift = 9:45 PM - 5:45 AM.

March 2015 - Census = 10 residents. One caregiver on evening shift on 3/1/15, 3/3/15, 3/10/15, 3/11/15, 3/13/15 and 3/17/15. Evening shift = 1:45 PM - 9:45 PM.

April 2015 - Census = 11 residents. One day caregiver on 4/2/15. Day shift = 5:45 AM - 1:45 PM.

May 2015 - Census = 11 residents. No night caregiver on 5/1/15, 5/2/15, 5/3/15, 5/9/15, 5/10/15, 5/15/15, 5/16/15, 5/17/15, 5/23/15, 5/24/15, 5/30/15 and 5/31/15. One caregiver on evening shift on 5/15/15 and 5/28/15.

June 2015 - Census = 12 residents. One day caregiver on 6/11/15.

July 2015 - Census = 12 residents. One day caregiver on 7/5/15. One evening caregiver on 7/3/15, 7/4/15, 7/13/15, 7/20/15 and 7/23/15.

September 2015 - Census = 10 residents. No night caregiver on 9/5/15, 9/6/15, 9/12/15, 9/13/15, 9/19/15, 9/20/15, 9/26/15 and 9/27/15 (all weekends). One day caregiver on 9/23/15. One evening caregiver on 9/17/15.

One medication technician on duty per shift for the entire facility.

On 11/23/15 in the afternoon, review of the facility's Resident Council Minutes revealed:

/18/14: "...Need more medication technicians not getting attention when needed Need more caregivers - 2 on each hall for 2 shifts. Wait time is too long, call light turned off and they forget to come back again...Caregivers are talking more non-English, upsetting to residents..."

-3/11/15: "...Need more caregivers - caregivers doing as well as they can..."

-7/8/15: "...wants caregivers to help more in kitchen and rooms. Need more help. Training needs to improve - new caregivers training new caregivers..."

-8/12/15: "...Takes too long to answer call lights. We see them standing in the hall talking. Some

days a resident needs help to get dressed and she was told to do it herself.

-9/9/15: "...Caregivers not doing their job chatting- not taking care of resident..."

On 10/1/15 in the afternoon, the Interim Executive Director reported caregiver meetings are conducted every month to address resident concerns. If it is known who the caregiver is, a one-on-one meeting is conducted with the employee and documented in internal meeting notes.

On 10/1/15 in the morning and afternoon, observed caregivers attending to residents in the dining room. Residents interviewed reported the caregivers help them in the dining room at every meal.

On 10/1/15 at 1:50 PM, the Interim Executive Director reported all medication technicians have caregiver and Alzheimer's training. There are two caregivers and one

medication technician for all shifts except memory care. There are two caregivers and a shower person (Shower person not listed on schedule as such). For memory care there are one to six caregivers at all times and one medication technician every shift. The Interim Executive Director reported that in early 2015, caregiver hours were cut from 40 hours to between 32 and 35 hours each except for memory care caregivers. Budgeting issues forced the cut of the shower person. The previous Administrator left in March 2015 and through controlled spending, the facility has restored staff to 40 hours, beginning late April 2015.

On 10/9/15 at 1:30 PM, Employee #12 reported that staffing usually works for them except when someone calls in sick. When that happens, the medication technician, Employee #5 and/or the Interim Executive Director assist. Employee #12 indicated that overall there was sufficient staffing to do their job, however at times the staffing was not sufficient.

Severity:: 2 Scope: 3
Complaint #NV00044032

Y 103 NAC 449.200(1)(d) Personnel File - NAC 441A /

Based on record review and interview, the facility failed to ensure 3 of 11 employees met the requirements concerning tuberculosis (TB) testing and pre-employment physical examination (Employee #1, #4 and #11).

Employee #1 was hired on 1/5/15. On 10/1/15 in the morning, review of the employee file revealed a pre-employment physical examination dated 1/15/15, after the hire date. The employee file revealed a two-step TB test with a final read date of 8/29/15, seven months after the hire date.

Employee #4 was hired on 9/22/14. On 10/1/15 in the morning, review of the employee file revealed a first step TB test with a read date of 2/27/14. The results could not be read. The employee file revealed documented evidence of a 2015 annual TB test with a read date of 5/23/15 and a negative result, beyond 364 dates from the previous TB test.

Employee #11 was hired on 7/8/14. On 10/1/15 in the morning, review of the employee file revealed a two-step TB test with a final read date of 7/16/14, after the hire date.

On 10/1/15 in the afternoon, the Interim Executive Director confirmed the deficiencies.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity: 2 Scope: 2

Y 105 NAC 449.200(1)(f) Personnel File - Background Check

Based on record review and interview, the facility failed to ensure 4 of 11 employees met background check requirements of NRS 449 (Employee #1, #3, #6 and #8).

Employee #1 was hired on 1/5/15. On 10/1/15 in the morning, the employee file lacked documented evidence of fingerprints and State and FBI background check results.

Employee #3 was hired on 10/16/14. On 10/1/15 in the morning, review of the employee file revealed an undecided FBI background check result dated 12/16/14. The employee file lacked documented evidence of a challenge or any action taken.

Employee #6 was hired on 3/27/15. On 10/1/15 in the morning, review of the employee file revealed a State and FBI background check not conducted through the Nevada Automated Background Check System (NABS). The fingerprints were taken on 7/1/15, three months after the hire date.

Employee #8 was hired on 9/23/15. On 10/1/15 in the morning, review of the employee file revealed a State and FBI background check not conducted through NABS.

On 10/1/15 at 2:15 PM, the Interim Executive Director acknowledged the deficiencies.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity: 2 Scope: 2

Y 178NAC 449.209(5) Health and Sanitation-Maintain Int/Ext

Based on observation and interview, the facility failed to ensure the premises were clean and maintained.

On 10/1/15 at 10:15 AM, during a tour of the facility observed heavily soiled carpet in Bedroom #14 and #30, the hallway and the west hallway between Rooms 1 through 15.

On 10/1/15 at 10:15 AM, the Maintenance Director acknowledged the condition of the carpet and the need for cleaning or replacement. The Maintenance Director reported the facility was replacing carpet with carpet squares on an as needed basis but with a budget of $36,000, this was limited.

Severity: 2 Scope: 3

Y 255 NAC 449.217(6)(a)(b) Permits - Comply with NAC 446 On Food Service

Based on observation on 10/1/15, the facility failed to ensure the kitchen complied with the standards of NAC 446.

1. Critical Violations:

a. The person in charge of the kitchen was not food safety certified at the time of inspection.

b. The low temperature dishmachine was not sanitizing at the time of inspection.

c. Multiple flies were observed throughout the kitchen and dining areas.

2. Major Violations:

a. The interior ice machine surfaces around the ice drop had pink grime "mold like" build-up.

3. Equipment and Maintenance Violations: a. Multiple light bulbs were burned out in the kitchen and dry storage areas.

Severity: 2 Scope: 3

Y 450 NAC 449.231(1) First Aid and CPR

Based on record review and interview, the facility failed to ensure 3 of 11 employees were trained in first aid and cardiopulmonary resuscitation (CPR) (Employee #2, #7 and #9).

Employee #2 was hired on 3/25/15 and began providing care to residents on 4/10/15. On 10/1/15 in the morning, the employee file revealed first aid and CPR training dated 5/26/15, beyond 30 days of hire.

Employee #7 was hired on 5/15/15 and began providing care to residents on 6/12/15. On 10/1/15 in the morning, the employee file revealed first aid and CPR training dated 8/18/15, beyond 30 days of hire.

Employee #9 was hired on 5/29/14. On 10/1/15 in the morning, review of the employee file revealed first aid and CPR training with a 10/4/14 expiration date. The employee file

revealed a lapse in renewal first aid and CPR training dated 11/21/14.

On 10/1/15 in the afternoon, the Interim Executive Director acknowledged the deficiencies.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity:2 Scope: 2

Y 590 NAC 449.268(1)(a) Resident Rights.

Based on record review and interview, the Administrator failed to ensure 1 of 47 residents was not neglected (Resident #14).

On 10/1/15, a review of Resident #14's file revealed the following:

-Resident #14 was admitted to the facility on 11/24/08. The resident's diagnoses as of the most recent physical examination documented in the file dated 6/20/14 included diabetes mellitus type II, chronic kidney disease stage III, hypertension, edema and anemia.

-Resident #14 was transported to the emergency room on 8/11/15 after they were found unresponsive by facility staff. The resident was admitted to the hospital on 8/11/15. A physician progress note dated 8/12/15 indicated upon physical examination the resident was found to be disheveled, had multiple bruises, a rash with excoriations and had multiple small decubital ulcers (pressure sores) on their legs and sacrum. The resident was diagnosed with pneumonia, sepsis, a urinary tract infection, advanced scabies and severe protein calorie malnutrition. The physician noted the resident had ample evidence of chronic elder abuse/neglect.

-The Resident Assessment and Care Plan dated 4/5/15 documented the resident had occasional incontinence that required staff assistance and the resident required assistance with bathing twice per week. Additionally, it documented the resident was independent or required no assistance with ambulation using wheelchair aides and the resident was able to transfer independently with staff assistance on standby for safety when needed.

-Review of an untitled log maintained by the facility, indicated for activities of daily living Resident #14 received caregiver assistance per the resident's service plan, which included assistance with bowel and bladder care, bathing and dressing. The log was initialed by caregivers three times daily for the day, evening and night shifts and included the time period from 1/1/15 through 8/10/15.

-The resident's file lacked documented evidence of facility care notes, progress notes, physician communication, or physician documentation regarding development and/or

treatment of pressure sores.

A review of the facility's Resident

Evaluation/Re-evaluation Period policy (undated), How To Make It Happen, After Admission, paragraph 3 read, in part, "...- 3. At regular time intervals as required by local and state regulation, and as necessary, re-evaluate the resident for changes in status. Evaluate the plan of care and change as appropriate."

A review of the facility's Alert Charting Policy and Procedure (undated), read, in part, "...- Purpose: To ensure that all residents with a change of condition are assessed and monitored appropriately and that there is documentation in the resident record to reflect the resident's condition...- Policy: Anytime a resident has a change of condition...alert charting will be initiated...- Procedure: When it is identified that resident was independent or required no assistance with ambulation using wheelchair aides and the resident was able to transfer independently with staff assistance on standby for safety when needed.

-Review of an untitled log maintained by the facility, indicated for activities of daily living Resident #14 received caregiver assistance per the resident's service plan, which included assistance with bowel and bladder care, bathing and dressing. The log was initialed by caregivers three times daily for the day, evening and night shifts and included the time period from 1/1/15 through 8/10/15.

-The resident's file lacked documented evidence of facility care notes, progress notes, physician communication, or physician documentation regarding development and/or treatment of pressure sores.

A review of the facility's Resident

Evaluation/Re-evaluation Period policy (undated), How To Make It Happen, After Admission, paragraph 3 read, in part, "...- 3. At regular time intervals as required by local and state regulation, and as necessary, re-evaluate the resident for changes in status. Evaluate the plan of care and change as appropriate."

A review of the facility's Alert Charting Policy and Procedure (undated), read, in part, "...- Purpose: To ensure that all residents with a change of condition are assessed and monitored appropriately and that there is documentation in the resident record to reflect the resident's condition...- Policy: Anytime a resident has a change of condition...alert charting will be initiated...- Procedure: When it is identified that the resident requires closer observation the designated staff will initiate alert charting by : record observations in the resident's care record...inform the resident's physician and/or family as indicated."

On 10/1/15 at 12:40 PM, the Health Services Manager (HSM) explained they noticed a decline in Resident #14's health condition approximately three weeks prior to the

resident's admission to the hospital. They further explained the resident had "bad diarrhea" daily and required showering five times per week because of the diarrhea. The HSM explained they observed skin breakdown on the resident approximately two to three weeks prior to the hospital admission. The facility maintained a Skin Report Log effective June 2015, however no entries for Resident #14 were noted on the log.

On 10/1/15 at 1:26 PM, Employee #6 explained they provided care for Resident #14 on the night shift. The employee further explained they observed a change in the resident's condition approximately one month prior to the resident's admission to the hospital. The resident "had a blank stare and wasn't all there mentally" and "became more secluded and wasn't their self". The resident sat in a wheelchair most of the time and needed assistance with transferring. The employee explained the resident sometimes smelled of urine. The resident used a urinal however frequently had accidents. The resident needed their incontinence briefs changed two to five times per shift due to diarrhea. Prior to the resident's decline in health, the resident received showers twice weekly. Once the resident's health declined, the resident received showers four to five times weekly. The employee explained they were "not sure" when asked if they noticed sores on the resident's bottom and lower back. The employee reported the facility's policy was for caregivers to report to medication technicians if they observed a change in a resident's condition.

On 10/1/15 at 2:49 PM, Employee #9, a medication technician, explained they noticed a decline in Resident #14's abilities approximately two months prior to the resident's admission to the hospital. The employee further explained the resident "was in and out of competency".

On 10/9/15 at 1:30 PM, Employee #12 explained they saw Resident #14 every other day. The employee further explained they observed a consistent decline in the resident's condition which began approximately December 2014. Shortly before the resident was admitted to the hospital on 8/11/15, the resident had frequent diarrhea and sometimes needed showers three times per shift. The employee recounted the resident's skin became irritated because of the frequency of the diarrhea. The employee explained they informed a number of medication technicians of the the skin irritation but couldn't remember the staff names because they varied .

Severity:3 Scope:1

Complaint #NV00043743

Y 783 NAC 449.27226(2)(a)(b) Diabetes

Based on record review and interview, the facility failed to ensure an employee did not make an assessment of a resident's blood glucose levels in order to determine if insulin should be administered (Resident #14).

The Medication Administration Record (MAR) for Resident #14 documented the resident was diagnosed with diabetes and self-administered the following per physician orders:

-Check and record blood glucose twice daily, order date 11/29/12

-Humalog mix, inject subcutaneously 30 units every morning for diabetes, hold if blood glucose less than 80, check blood sugar prior to giving, order date 8/13/12

-Humalog mix, inject subcutaneously 15 units every evening for diabetes, hold if blood glucose less than 80, check blood sugar prior to giving, order date 8/13/12

The medication technicians recorded the results of the blood glucose testing and documented the administration of insulin on the MAR.

On 10/1/15 at 12:40 PM, the Health Services Manager (HSM) acknowledged Resident #14's insulin order had parameters for administration which was to hold the administration of insulin if the resident's blood glucose levels were less than 80. On 6/17/14, the facility requested the physician remove the parameters but the physician determined they were to remain on the order. The HSM recounted they noticed a decline in Resident #14's health condition approximately three weeks prior to the resident's admission to the hospital on 8/11/15. The manager further explained the resident seemed "confused and out of it". There was no documented evidence a physician was notified of the resident's change in condition.

On 10/1/15 at 2:49 PM, Employee #9, a medication technician, explained they noticed a decline in Resident #14's abilities approximately two months prior to the resident's admission to the hospital. The employee further explained the resident "was in and out of competency". The employee explained if they thought the resident needed a shot, they encouraged the resident to take insulin as the resident was sometimes confused. The employee reported if the resident's blood sugar was approximately 130-140, they usually had to recommend to the resident they administer their insulin and would hand the insulin to the resident.

Severity:3 Scope:1
Complaint #NV99943743

Y 859 NAC 449.274(5) Periodic Physical examination of a resident

Based on record review and interview, the facility failed to ensure 2 of 15 residents received an initial or annual physical examination (Resident #11 and #14).

Resident #11 was admitted on 6/2/15. On 10/1/15 in the morning, the resident file lacked documented evidence of an initial physical examination.

Resident #14 was admitted on 11/24/08. On 10/1/15 in the morning, review of the resident file revealed a physical examination dated 7/2014. The resident file lacked documented evidence of a 2015 annual physical examination.

On 10/1/15 at 12:40 PM, the Interim Executive Director confirmed the missing documentation.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity: 2 Scope: 1

Y 861 NAC 449.274(6)(b) Medical Care

Based on record review and interview, the facility staff failed to monitor the ability of a resident to care for their own health conditions and document in writing any significant change in their ability to care for those conditions (Resident #14).

On 10/1/15, a review of Resident #14's file revealed the following:

Resident #14 was admitted to the facility on 11/24/08. The most recent physical examination documented in the file was dated 6/20/14 and included diagnoses of diabetes mellitus type II, chronic kidney disease stage III, hypertension, edema and anemia.

The Medication Administration Record (MAR) for Resident #14 documented the resident was diagnosed with diabetes. The resident had physician orders to check blood glucose levels twice daily and inject insulin in the morning and in the evening, hold the insulin if their blood glucose level was less than 80. The medication technicians recorded the results of the blood glucose testing and documented the administration of insulin on the MAR.

An Incident Report dated 7/21/15 documented "resident sleeping, would not open

eyes or eat, and speaking gibberish". Paramedics were called. The report documented the resident's blood glucose was 48.

An Incident Report dated 8/11/15 documented "resident found to be unresponsive, sent to the emergency room for evaluation". A history and physical examination dated 8/11/15 documented upon admission to the emergency room, the resident had hypoglycemia with a blood glucose level of 17.

On 8/11/15, a history and physical examination documented the resident was dehydrated upon hospital admission. On 8/12/15, a hospital physician progress note documented upon physical examination, the resident was found to be disheveled, had multiple bruises, a rash with excoriations and had multiple small decubital ulcers (pressure sores) on their legs and sacrum. The resident was diagnosed with pneumonia, sepsis, a urinary tract infection, advanced scabies and severe protein calorie malnutrition.

The current Resident Assessment and Care Plan dated 4/15/15 documented Resident #14 self-injected insulin twice daily, had occasional incontinence which required staff assistance , required assistance with bathing twice per week, was independent or required no assistance with ambulation using wheelchair aides, and the resident was able to transfer independently with staff assistance on standby for safety when needed. No updated assessment was documented in the file.

A review of the facility's Resident

Evaluation/Re-evaluation Period policy (undated), How To Make It Happen, After Admission, paragraph 3 read, in part, "...- 3. At regular time intervals as required by local and state regulation, and as necessary, re-evaluate the resident for changes in status. Evaluate the plan of care and change as appropriate."

A review of the facility's Alert Charting Policy and Procedure (undated), read, in part, "...- Purpose: To ensure that all residents with a change of condition are assessed and monitored appropriately and that there is documentation in the resident record to reflect the resident's condition...- Policy: Anytime a resident has a change of condition...alert charting will be initiated...- Procedure: When it is identified that the resident requires closer observation the designated staff will initiate alert charting by : record observations in the resident's care record...inform the resident's physician and/or family as indicated."

On 10/1/15 at 12:40 PM, the Health Services Manager (HSM) explained they noticed a decline in Resident #14's health condition approximately three weeks prior to the resident's admission to the hospital on 8/11/15. The manager further explained the resident seemed "confused and out of it". The resident began to neglect their cat, had problems with their blood sugar and had "bad diarrhea" and stopped eating approximately one week prior to admission to the hospital. The HSM explained they texted the resident's clinician regarding their decline in condition, but admitted they failed to document physician notification and any physician communication.

On 10/1/15 at 1:26 PM, Employee #6 explained they observed a change in the resident's condition approximately one month prior to the resident's admission to the hospital. The resident "had a blank stare and wasn't all there mentally" and "became more secluded and wasn't their self". The resident had frequent diarrhea and needed their incontinence briefs changed two to five times per shift. The resident received four to five showers weekly due to increased incontinence. The resident needed assistance with transfers and could no longer transfer independently.

On 10/1/15 at 2:49 PM, Employee #9, a medication technician, explained they noticed a decline in Resident #14's abilities approximately two months prior to the resident's admission to the hospital. The employee further explained the resident "was in and out of competency". The employee explained if they thought the resident needed a shot, they encouraged the resident to take insulin as the resident was sometimes confused. The employee reported if the resident's blood sugar was approximately 130-140, they usually had to recommend to the resident they administer their insulin and would hand the insulin to the resident.

On 10/9/15 at 1:30 PM, Employee #12 explained they observed a consistent decline in the resident's condition which began approximately December 2014. The employee further explained the resident had frequent diarrhea and sometimes needed showers three times per shift. The employee recounted the resident's skin became irritated because of the frequency of the diarrhea.

Severity:3 Scope:1

Complaint #NV00043743

Y 878 NAC 449.2742(5)(6) Medication / OTCs,.

Based on observation, document review, record review and interview, the facility failed to ensure medications were on site to administer for 9 of 13 residents (Resident #1, #2, #5, #6, #7, #8, #9, #11 and #13).

Resident #1 was admitted on 7/15/14 with primary diagnoses of diabetes, vascular ulcers and osteomylitis. On 10/1/15 in the afternoon, review of medications for the resident revealed Artifi Tears Sol-Op, instill in eyes as needed for dry eyes was not on site to administer.

Gabapentin 300 mg capsule, take 3 capsules twice daily was not on site to administer for 9/3/15 5:00 PM dose, 9/4/15 9:00 AM and 5:00 PM dose and 9/5/15 9:00 AM dose. Gabapentin is used to treat nerve pain associated with diabetic neuropathy.

Resident #2 was admitted on 1/20/15 with a primary diagnosis of Alzheimer's disease. On 10/1/15 in the afternoon, review of medications for the resident revealed Refresh Plus Drops 0.5% OP, instill 1 drop into each eye 4 times daily for dry eyes was not on site to administer.

Resident #5 was admitted on 9/10/15 with primary diagnoses of bipolar disorder with schizophrenia and debility. On 10/1/15 in the afternoon, review of medications for the resident revealed Tramadol HCL 50 mg, take 1 tablet every 6 hours as needed for pain was not on site to administer on 9/29/15, 9/30/15 and 10/1/15. The Medication Administration Record (MAR) noted the medication was a narcotic and must be ordered seven days in advance. There was no documentation the medication had been reordered. The MAR and Pass Notes did not indicate the medication was not available.

-On 10/1/15 at 10:50 AM, Resident #5 reported they had not received the Tramadol since 9/28/15 and indicated they had been tapering down as they were told by the facility the Tramadol was running out as of 10/1/15.

-On 10/1/15 in the afternoon, review of the MAR as needed tracking for Resident #5 revealed the resident had taken Tramadol daily for pain, once on 9/12/15, 9/16/15 and 9/21/15, twice on 9/11/15, 9/14/15, 9/15/15, 9/16/15, 9/17/15, 9/18/15, 9/19/15, 9/20/15, 9/23/15, 9/26/15 and 9/28/15 and three times on 9/13/15, 9/22/15, 9/25/15 and 9/27/15. No Tramadol was available or administered after 9/27/15.

-On 10/1/15 in the afternoon, review of the MAR for Resident #5 revealed Amlodipine 10 mg, 1 tablet every morning was not on site to administer on 9/20/15, 9/21/15 and 9/22/15 9:00 AM doses. Divalproex 250 mg ER, take 2 tablet daily was not on site to administer on 9/20/15, 9/21/15 and 9/22/15 9:00 AM doses. Ferrous Sulfate 325 mg, take 1 tablet twice daily was not on site to administer on 9/21/15 and 9/22/15 9:00 AM doses and 9/20/15, 9/21/15 and 9/22/15 5:00 PM doses. Hydrocortisone 1% cream 28.4 gram, apply topically to the affected area twice daily was not on site to administer on 9/16/15, 9/17/15, 9/18/15, 9/19/15, 9/20/15 and 9/26/15 9:00 PM doses and on 9/20/15 and 9/21/15 9:00 PM doses. Levothyroxine 112 micrograms, take 1 tablet every morning was not available to administer on 9/21/15 and 9/22/15 7:00 AM doses. Nicotine TD DIS 7 mg/24 hr, apply 1 patch topically daily at bedtime was not on site to administer on 9/16/15, 9/19/15, 9/20/15, 9/21/15 and 9/22/15 8:00 PM application. Pantoprazole 40 mg, take 1 tablet daily was not on site to administer on 9/20/15, 9/21/15 and 9/22/15 9:00 AM doses. For all of these medications the MAR documented the medications were not cycle fill until the facility requests.

Resident #6 was admitted on 7/8/14. On 10/1/15 in the afternoon, review of the medications for the resident revealed Triamcinolone Cream 0.1%, apply 2 grams (gm) to rash on trunk twice daily for 14 days beginning 9/5/15. The 9/5/15 5:00 PM dose was not on site to administer. Risperidone 0.25 mg, take 1 tablet at bedtime was

not on site to administer for the 9/14/15 8:00 PM dose. Lutein 20 mg, take 1 capsule daily was not on site to administer for the 9/27/15 9:00 AM dose.

Resident #7 was admitted on 6/15/15 with a primary diagnosis of dementia with behavioral disturbances. On 10/1/15 in the afternoon, review of the medications for the resident revealed Famotidine 20 mg, take 1 tablet twice daily for gastrointestinal distress was not on site to administer for the 9/16/15 5:00 PM dose. Phenytoin SUS 125 mg/5 milliliter (ml), take 5 mls 3 times daily for senile dementia was not on site to administer for the 9/9/15 and 9/10/15 6:00 PM doses.

Resident #8 was admitted on 5/5/15. On 10/1/15 in the afternoon, review of the medications for the resident revealed Hydrocodone/APAP 5-325 mg, take 1 tablet 3 times daily as needed for pain for 5 days was not on site to administer. The medication was ordered on 9/26/15.

Resident #9 was admitted on 4/13/15 with primary diagnoses of atrial fibrillation, hypertension and rhabdomyolysis. On 10/1/15 in the afternoon, review of the medications for the resident revealed Proair HFA, inhale 2 puffs every 4 hours as needed for rescue was not on site to administer.

Resident #11 was admitted on 6/2/15. On 10/1/15 in the afternoon, review of the medications for the resident revealed Docusate 100 mg, take 1 capsule twice daily for bowel movement was not on site to administer.

Resident #13 was admitted on 4/28/15 with primary diagnoses of dementia and hyperderma. On 10/1/15 in the afternoon, review of the medications for the resident revealed Zolpidem 5 mg, take 1 tablet at bedtime for sleep was not on site to administer for the 9/15/15 and 9/16/15 8:00 PM doses.

On 10/1/15 in the afternoon, the resident Ultimate User Agreement signed by all of the residents, their guardian or power of attorney read, in part, "...If an emergency event we utilize Northwest Health Systems to fill orders for medications for residents who have chosen to use their own pharmacy, a $100 fee will be charged. (Note: VA and Indian Health Pharmacy users are exempt from this fee.)...I authorize the Homestead to order a one week supply of medications from CVS or Walgreens if I have not delivered medications, from my own pharmacy, to the facility in a timely manner or if it is an emergency order. I will be responsible for payment to CVS or Walgreens for such medications."

On 10/1/15 in the afternoon, the Medication Technicians on duty confirmed the missing medications.

This was a repeat deficiency from the 11/21/14 State Licensure re-survey and annual survey and the 8/25/14 re-survey and complaint investigation.

Severity:3 Scope: 3

Y 936 NAC 449.2749(1)(e) Resident file-NRS 441A. Tuberculosis

Based on record review and interview, the facility failed to ensure 5 of 15 residents met the requirements concerning tuberculosis (TB) testing (Resident #3, #5, #7, #9 and #10).

Resident #3 was admitted on 9/3/15. On 10/1/15 in the morning, the resident file lacked documented evidence of a two-step TB test.

Resident #5 was admitted on 9/10/15. On 10/1/15 in the morning, the resident file lacked documented evidence of a two-step TB test.

Resident #7 was admitted on 6/15/15. On 10/1/15 in the morning, review of the resident file revealed a one-step TB test with a read date of 6/13/15 and a negative result. The resident file lacked documented evidence of a second step TB test.

Resident #9 was admitted on 4/13/15. On 10/1/15 in the morning, the resident file lacked documented evidence of a two-step TB test.

Resident #10 was admitted on 1/12/15. On 10/1/15 in the morning, review of the resident file revealed a second step TB test with a 1/5/15 inject date. The resident file lacked documented evidence of a read date or results.

On 10/1/15 at 12:40 PM, the Interim Executive Director confirmed the missing documentation and indicated that in the future they will be sure to have TB tests completed prior to resident admission or a physician order in hand.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity:2 Scope: 2

Y 966 NAC 449.2754(5)(b) Alzheimer's Policies.

Based on document review, observation and interview, the facility failed to ensure there was one caregiver per six residents during hours when the residents were awake.

The facility Ombudsman from Aging and Disability Services Division (ADSD) reported that during visits on 7/6/15, 8/10/15 and 9/9/15, interviews were conducted with several residents who were alert and oriented. The residents voiced concerns about inadequate staffing at the facility . On 7/6/15, the Interim Director indicated to the ADSD Ombudsman they would request approval for a full time caregiver. On 9/9/15, the Interim Director reported to the ADSD Ombudsman they were not approved for an additional caregiver due to the independence level of many of the residents.

On 10/1/15 at 1:50 PM, the Interim Executive Director reported there is one caregiver to every six residents at all times and one medication technician every shift.

On 10/1/15 in the morning and afternoon, observed caregivers attending to residents in the dining room. Residents interviewed reported the caregivers help them in the dining room at every meal.

On 11/17/15 in the afternoon, review of census and staffing schedules for the Memory Care (MC) unit revealed:

-February 2015 - Census = 10 residents. No night shift caregiver in MC between 2/1/15 2/28/15. Night shift = 9:45 PM - 5:45 AM.

-March 2015- Census = 10 residents. One caregiver on evening shift on 3/1/15, 3/3/15, 3/10/15, 3/11/15, 3/13/15 and 3/17/15. Evening shift = 1:45 PM - 9:45 PM.

-April 2015 - Census = 11 residents. One day caregiver on 4/2/15. Day shift = 5:45 AM - 1:45 PM.

-May 2015 - Census = 11 residents. No night shift caregiver on 5/1/15, 5/2/15, 5/3/15, 5/9/15, 5/10/15, 5/15/15, 5/16/15, 5/17/15, 5/23/15, 5/24/15, 5/30/15 and 5/31/15. One caregiver on evening shift on 5/15/15 and 5/28/15.

-June 2015 - Census = 12 residents. One day caregiver on 6/11/15.

-July 2015 - Census = 12 residents. One day caregiver on 7/5/15. One evening caregiver on 7/3/15, 7/4/15, 7/13/15, 7/20/15 and 7/23/15.

-September 2015 - Census = 10 residents. No night caregiver on 9/5/15, 9/6/15, 9/12/15, 9/13/15, 9/19/15, 9/20/15, 9/26/15 and 9/27/15 (all weekends). One day caregiver on 9/23/15. One evening caregiver on 9/17/15.

-One medication technician on duty per shift for the entire facility.

On 11/13/15 in the afternoon, review of the facility's Resident Council Minutes revealed:

/18/14: "...Need more medication technicians not getting attention when needed

Need more caregivers - 2 on each hall for 2 shifts. Wait time is too long, call light turned off and they forget to come back again...Caregivers are talking more non-English, upsetting to residents..."

-3/11/15: "...Need more caregivers - caregivers doing as well as they can..."

-7/8/15: "...wants caregivers to help more in kitchen and rooms. Need more help. Training needs to improve - new caregivers training new caregivers..."

-8/12/15: "...Takes too long to answer call lights. We see them standing in the hall talking. Some days a resident needs help to get dressed and she was told to do it herself.

-9/9/15: "...Caregivers not doing their job chatting- not taking care of resident..."

On 10/1/15 in the afternoon, the Interim Executive Director reported caregiver meetings take place every month to discuss concerns. If it is known who the caregiver is, management has a one-on-one with the employee. This information is documented in internal meeting notes.

Severity:2 Scope:3

Complaint #NV00044032

Y991 NAC 449.2756(1)(b) Alzhiemer's Fac door alarm

Based on observation and interview, the facility failed to ensure exit doors had installed alarms that operated when the exit door was opened.

On 10/1/15 at 10:00 AM, during a tour of the facility observed the patio door in the memory care unit was not on. When the Maintenance Director turned the alarm on, it did not operate consistently.

On 10/1/15 at 10:10 AM, observed the alarm on Room #15, with a door leading to the memory care patio, was turned off.

On 10/1/15 at 10:10 AM, the Maintenance Director confirmed the observations indicating knowledge of the requirement for the alarms to be turned on and functional at all times.

This is a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity:2 Scope: 3

Y 992 NAC 449.2756(1)(c) Alzheimer's Fac awake staff

Based on document review and interview, the facility failed to ensure one member of the staff was on duty and awake at the facility at all times.

The facility Ombudsman from Aging and Disability Services Division (ADSD) reported that during visits on 7/6/15, 8/10/15 and 9/9/15, interviews were conducted with several residents who were alert and oriented. The residents voiced concerns about inadequate staffing at the facility .

On 10/1/15 at 1:50 PM, the Interim Executive Director reported in the Memory Care (MC) unit there is one caregiver to every six residents at all times and one medication technician every shift.

On 11/17/15 in the afternoon, review of census and staffing schedules for the Memory Care (MC) unit revealed:

-February 2015 - Census = 10 residents. No night shift caregiver in MC between 2/1/15 2/28/15. Night shift = 9:45 PM - 5:45 AM.

-May 2015 - Census = 11 residents. No night shift caregiver on 5/1/15, 5/2/15, 5/3/15, 5/9/15,

5/10/15, 5/15/15, 5/16/15, 5/17/15, 5/23/15, 5/24/15, 5/30/15 and 5/31/15.

-September 2015 - Census = 10 residents. No night caregiver on 9/5/15, 9/6/15, 9/12/15, 9/13/15, 9/19/15, 9/20/15, 9/26/15 and 9/27/15 (all weekends).

Severity:2 Scope:3

Complaint #NV00044032

Y1010 NAC 449.2764(1) Mental Illness Endorsement.

Based on record review, the facility failed to obtain a mental illness endorsement.

Upon admission to a hospital on 7/20/15, a History and Physical dated 7/20/15 for Resident #5 indicated, along with the diagnoses of bipolar disorder with schizophrenia, debility, psychogenic polydipsia, chronic obstructive pulmonary disease and hypertension, the resident had been admitted to a psychiatric hospital in December 2014. The resident was admitted due to noncompliance of medications and inability to

completely understand and care for themselves. The document also indicated the resident had psychogenic polydipsia, the retention of water caused by mental disorders.

Upon discharge from the hospital on 9/3/15, a Discharge Summary dated 9/3/15 read in part, "...Bipolar disease on Depakote. The patient's last Depakote level appeared to be slightly low..." The Depakote dosage was increased from 250 milligrams (mg) daily to extended release 500 mg daily at that time.

Resident #5 was admitted to the facility on 9/10/15, with primary diagnoses of bipolar disorder with schizophrenia and debility indicated on the signed Move-In Orders and Plan of Care. It was also noted in the Physical and Cognitive Condition section the resident had "inappropriate behavior".

Upon admission to the facility on 9/10/15, medications included Depakote extended release 500 mg daily, Hydroxyzine 25 mg three times daily as needed (PRN) and Tramadol 50 mg daily for moderate to severe pain.

Severity: 2 Scope: 1

Y1035 NAC 449.2768(1)(a)(1) Dementia Training.

Based on record review and interview, the facility failed to ensure 1 of 11 employees acquired two hours of Alzheimer's training with the first 40 hours of employment (Employee #11). Findings include:

Employee #11 was hired on 7/8/14. On 10/1/15 in the morning, review of the employee file revealed one hour of Alzheimer's training dated 7/19/15.

On 10/1/15 at 2:15 PM, the Interim Director confirmed the missing documentation.

This was a repeat deficiency from the 8/25/14 State Licensure re-survey and complaint investigation.

Severity: 2 Scope: 1

Y1036 NAC 449.2768(1)(a)(2) Dementia Training.

Based on record review and interview, the facility failed to ensure 1 of 11 employees acquired eight hours of Alzheimer's training with the first 90 days of employment (Employee #11).

Employee #11 was hired on 7/8/14. On 10/1/15 in the afternoon, review of the employee file revealed one hour of Alzheimer's training since 7/8/14.

On 10/1/15 at 2:15 PM, the Interim Executive Director confirmed the deficiency.

Severity: 2 Scope: 1

Y1038 NAC 449.2768(1)(a)(4) Dementia Training.

Based on record review and interview, the facility failed to ensure 3 of 11 employees completed the required minimum of three hours of training in providing care to a resident with dementia by the hire anniversary date and annually. (Employee #4, #9 and #11).

Employee #4 was hired on 9/22/14. On 10/1/15 in the afternoon, review of the employee file revealed nine and one half hours of Alzheimer 's training since 9/22/14, dated 11/6/14.

Employee #9 was hired on 5/29/14. On 10/1/15 in the afternoon, review of the employee file revealed one hour of Alzheimer's training since the hire date, dated 7/19/15.

Employee #11 was hired on 7/8/14. On 10/1/15 in the afternoon, review of the employee file revealed one hour of Alzheimer's training since 7/8/14.

On 10/1/15 at 2:15 PM, the Interim Executive Director confirmed the deficiency.

Severity:2 Scope: 2

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**5/13/2016**
Case No.:	**B-36140**
Administrator:	**Lalaine E. Villahermosa**
License No.	**RFA 9365**
Admin of Record:	**8/21/14 to present**
Referral from:	**DPBH**
Survey Date:	**3/15/2016**
Survey due to:	**Complaint Invesigation**
Facility:	**Las Vegas Alzheimer and Memory Care** **3224 Brazos St.** **Las Vegas 89109**
Number of Beds:	**10**

PROPOSED DISCIPLINE

Fine:	$ **10,000.00**
Admin Cost:	**375.00**
Training Cost:	**100.00**
Training:	**Best Practices Modules 1 and 4**

DATE OF SURVEY 03/15/2016 Surveyor Minou Nelson at 702-486-6515 ext. 277.

Y 592 NAC 449.268(1)(c) Resident Rights.

Based on interview and record review, the facility failed to ensure 911 or the coroner was called timely following the death of a resident (Resident #1).

Resident #1 was a 89 year old male admitted to the facility on 04/10/13 with a diagnosis of chronic kidney disease Stage II, dementia and anemia. **The resident did not have a Do Not Resuscitate Order (DNR) in place and was a recipient of home health care services.**

Interview with Caregiver #1 and Caregiver #2 revealed on 01/24/16 at approximately 11:00 AM, both caregivers took Resident #1 to the resident's bedroom to provide incontinent care, a sponge bath and change the resident's clothing. While tending to the resident, both caregivers observed the resident experience difficulty breathing . Both caregivers watched the resident's breathing become more shallow and later stop. Neither caregiver called 911. Caregiver #1 said the resident's eyes looked as though the resident died. The caregiver checked for a pulse and did not find one.

Caregiver #2 called the facility manager (who was off duty) and informed the facility manager of the resident's death. The caregivers left the resident in the resident's bed.

The facility manager did not call 911 and instead called the resident's home health agency to report the resident's death. The home health agency advised the facility manager to contact the resident's public guardian and notify the guardian of the resident's death. The facility manager called and left a message for the resident's public guardian.

On 01/25/16 at 8:00 AM, the faculty manager arrived to the facility and observed the deceased resident was still in the resident's bed. The facility manager called the home health agency who advised the facility manager to call 911. Emergency Medical Services (EMS) and Metropolitan Police Department arrived to the facility shortly after 911 was called. The Clark County Coroner arrived to the facility and removed the resident's body at approximately 11:00 AM -which was an estimated 12 hours after the resident's death.

A facility progress note documented the caregiver called the facility manager and informed the facility manager of the resident's death on 01/24/16 at 12:11 PM .

The facility manager reported the expectation after a resident dies in the facility is to contact 911 or hospice (if the resident was a hospice recipient). Caregiver #1 and #2 said the facility policy and standard of practice it to contact the facility manager in the event of emergency.

Severity: 2 Scope: 1

Y 851 NAC 449.274(1)(b) Medical Care of Resident.

Based on interview and record review, the facility failed to ensure emergency medical services were obtained for a resident who experienced difficulty breathing and later stopped breathing (Resident #1).

Resident #1 was a 89 year old male admitted to the facility on 04/10/13 with a diagnosis of chronic kidney disease Stage II, dementia and anemia. The resident was deemed as full code and did not have a Do Not Resuscitate Order (DNR) in place. The resident was a recipient of home health care services.

Interview with Caregiver #1 and Caregiver #2 revealed on 01/24/16 at approximately 11:00 AM, both caregivers took Resident #1 to the resident's bedroom to provide incontinent care, a sponge bath and change the resident's clothing. While tending to the resident, both caregivers observed the resident experience difficulty breathing . Both caregivers watched the resident's breathing become more shallow and later stop. Neither caregiver called 911. Caregiver #1 said the resident's eyes looked as though the resident died. The caregiver checked for a pulse and did not find one. Caregiver #2 called the facility manager (who was off duty) and informed the facility manager of the resident's death. The caregivers left the resident in the resident's bed.

The facility manager did not call 911 and instead called the resident's home health agency to report the resident's death. The home health agency advised the facility manager to contact the resident's public guardian and notify the guardian of the resident's death. The facility manager called and left a message for the resident's public guardian.

On 01/25/16 at 8:00 AM, the faculty manager arrived to the facility and observed the deceased resident was still in the resident's bed. The facility manager called the home health agency who advised the facility manager to call 911. Emergency Medical Services (EMS) and Metropolitan Police Department arrived to the facility shortly after 911 was called. The Clark County Coroner arrived to the facility and removed the resident's body at approximately 11:00 AM -which was an estimated 12 hours after the resident's death.

A facility progress note documented the caregiver called the facility manager and informed the facility manager of the resident's death on 01/24/16 at 12:11 PM .

The facility manager reported the expectation after a resident dies in the facility is to

contact 911 or hospice (if the resident was a hospice recipient). Caregiver #1 and #2 said the facility policy and standard of practice it to contact the facility manager in the event of emergency.

Severity: 4 Scope: 1

Y 856 NAC 449.274(4)(a) Medical Care / Records.

Based on interview and record review, the facility failed to ensure caregivers attempted cardiopulmonary resuscitation (CPR) on a resident after they observed a resident experience difficulty breathing and later stopped breathing (Resident #1).

Resident #1 was a 89 year old male admitted to the facility on 04/10/13 with a diagnosis of chronic kidney disease Stage II, dementia and anemia. The resident was deemed as full code and did not have a Do Not Resuscitate Order (DNR) in place. The resident was a recipient of home health care services.

Interview with Caregiver #1 and Caregiver #2 revealed on 01/24/16 at approximately 11:00 AM, both caregivers took Resident #1 to the resident's bedroom to provide incontinent care, a sponge bath and change the resident's clothing. While tending to the resident, both caregivers observed the resident experience difficulty breathing . Both caregivers watched the resident's breathing become more shallow and later stop. Neither caregiver called 911. Caregiver #1 said the resident's eyes looked as though the resident died. The caregiver checked for a pulse and did not find one. Caregiver #2 called the facility manager (who was off duty) and informed the facility manager of the resident's death. The caregivers left the resident in the resident's bed.

The facility manager did not call 911 and instead called the resident's home health agency to report the resident's death. The home health agency advised the facility manager to contact the resident's public guardian and notify the guardian of the resident's death. The facility manager called and left a message for the resident's public guardian.

On 01/25/16 at 8:00 AM, the faculty manager arrived to the facility and observed the deceased resident was still in the resident's bed. The facility manager called the home health agency and advised the facility manager to call 911.

Emergency Medical Services (EMS) and Metropolitan Police Department arrived to the facility shortly after 911 was called. The Clark County Coroner arrived to the facility and removed the resident's body at approximately 11:00 AM -which was an estimated 12 hours after the resident's death.

A facility progress note documented the caregiver called the facility manager and informed the facility manager of the resident's death on 01/24/16 at 12:11 PM .

The facility manager reported the expectation after a resident dies in the facility is to contact 911 or hospice (if the resident was a hospice recipient). Caregiver #1 and #2 said the facility policy and standard of practice it to contact the facility manager in the event of emergency.

Review of facility files documented Caregiver #1 and #2 were both current in CPR training. Caregiver #1 CPR training was completed on 10/15/14 and expired on 10/15/16. Caregiver #2 CPR training was completed on 06/10/15 and expired on 06/10/17.

Severity: 4 Scope:1

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**5/13/2016**
Case No.:	**B-36141**
Administrator:	**Luz Aquino**
License No.	**RFA 8036**
Admin of Record:	**7/1/15 to present**
Referral from:	**DPBH**
Survey Date:	**3/10/2016**
Survey due to:	**Complaint Invesigation**
Facility:	**Angels House Adult Care** **5496 Tamarus St.** **Las Vegas 89119**
Number of Beds:	**9**

PROPOSED DISCIPLINE

Fine:	$ **500.00**
Admin Cost:	**375.00**
Training Cost:	**150.00**
Training:	**Best Practices Modules 1, 3 and 4**

DATE OF SURVEY 03/10/2016 Surveyor Johna Thacker at 702-486-6515 ext. 236.

Y 050 NAC 449.194(1) Administrator's. Responsibilities- Oversight

Based on observation, record review, and interview, the Administrator failed to provide oversight and guidance to ensure residents were treated with dignity and respect, were allowed to make their own decisions whenever possible, and were not prohibited from speaking to any persons who advocates for the rights of the residents of the facility.

See TAG Y 591, TAG Y 592, and TAG Y 595.

Severity:3 Scope: 1 1

Y591 NAC 449.268(1)(b) Resident Rights

Based on record review and interview, the facility failed to ensure 1 of 5 residents was not prohibited from speaking to any persons who advocates for the rights of the residents of the facility (Resident #1).

Resident #1 was admitted on 4/14/15 with a diagnosis including acute .cerebrovascular accident, left-sided hemiparesis, and coronary artery disease.

On 3/10/16 in the morning, during an interview, Resident #1 reported the facility owner decided the resident would be moved from the facility to the owner's residence. The owner packed up the resident's clothing, took resident to owner's car and moved resident without offering a reason . The resident reported they believed that the move was related to the recent visits from social workers. The resident stated, in reference to the owner, "she controls my life" and "she keeps me off-balance".

A report submitted by Elder Protective Services (EPS) indicated that the resident gave EPS permission to investigate an allegation of exploitation against the owner. On 2/26/16, EPS made a follow up telephone call to the resident and was told by a caregiver and the owner, the resident left the facility with a friend and had no forwarding address or phone number. A missing persons report was filed.

Severity: 3 Scope: 1

Y592 NAC 449.268(1)(c)Resident Rights

Based on documents and interviews, the facility failed to ensure 1 of 5 residents were treated with dignity and respect (Resident #1).

Resident #1:

Resident #1 was admitted on 4/14/15 with a diagnosis including acute cerebrovascular accident, left-sided hemiparesis, and coronary artery disease.

On 3/10/16 in the morning, during an interview, Resident #1 reported the facility owner decided the resident would be moved from the facility to the owner's residence. The owner packed up the resident's clothing, took resident to owner's car and moved resident without offering a reason . The resident reported they believed that the move was related to the recent visits from social workers. The resident stated, in reference to the owner, "she controls my life" and "she keeps me off-balance".

Review of report submitted by Aging and Disability Services Division (ADSD) revealed the resident reported the owner said if they were not added to the resident's accounts as a beneficiary, the resident's organs would be donated for research. The owner's name was listed on bank documents for the resident's accounts. ADSD determined allegations of exploitation and isolation had been substantiated.

Severity: 3 Scope: 1

Y595 NAC 449.268(1)(f) Resident Rights

Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents was allowed to make their own decisions whenever possible(Resident #1).

Resident #1 was admitted on 4/14/15 with a diagnosis including acute cerebrovascular accident, left-sided hemiparesis, and coronary artery disease.

On 3/10/16 in the morning, during an interview, Resident #1 reported the facility owner decided the resident would be moved from the facility to the owner's residence. The owner packed up the resident's clothing, took resident to owner's car and moved resident without offering a reason . The resident reported they believed that the move was related to the recent visits from social workers. The resident stated, in reference to the owner, "she controls my life" and "she keeps me off-balance".

Severity: 3 Scope: 1