NEVADA BOARD OF EXAMINERS
FOR
LONG TERM CARE ADMINISTRATORS

QUARTERLY BOARD MEETING

October 25, 2016

TABLE OF CONTENTS

1

STATE OF NEVDA
BOARD OF EXAMINERS FOR LONG-TERM CARE ADMINISTRATORS
3157 North Rainbow Boulevard, #313
Las Vegas, Nevada 89108
Telephone: 702-486-5445 Fax: 702-486-5439
Website: www.beltca.nv.gov
E-mail: beltca@beltca.nv.gov

MEETING NOTICE AND AGENDA

Date & Time:	**Tuesday, October 25, 2016 – 9:30 a.m.**
Place of Meeting:	**Sawyer State Office Building** **555 East Washington Avenue** **Room 4412** **Las Vegas, Nevada 89102**
	and
Video Conferencing:	**Legislative Counsel Bureau** **401 South Carson Street** **Room 3138** **Carson City, Nevada 89701**

All times are approximate. The Board reserves the right to take items in a different order, items may be combined for consideration by the Public Body and items may be pulled or removed at any time to accomplish business in the most efficient manner.

In certain situations, the option exists to declare the meeting on that agenda item to be a Closed (Executive) Session per NRS 241.030.

I. OPEN MEETING

II. ROLL CALL

III. PUBLIC COMMENTS

This item is to receive comments, limited to five (5) minutes, on any issue and any discussion of those items. However, no action will be taken on an item raised during Public Comments. Comments based on viewpoint are welcome.

IV. APPROVAL OF THE FOLLOWING PROPOSED DISCIPLINARY ACTION** (Board may go into closed session) "for possible action"

a. Prescila Barcelon – St. Jean Sr. Care – Case No. B-36116 & B-36117
b. Belinda Devano – Life Share Care Home – Case No. B-36144
c. Hermando Esguerra – Angel Prestige – Case No. B-36143
d. Florentino Leanillo – Family Home Care RHL – Case No. B-36149
e. Barry Wicklund – Addie's Home Care Inc – Case No. B-36145
f. Assaad B. Zeid – Morningstar of Sparks – Case No. B-36142

V. SECRETARY'S REPORT:

a. Approve Minutes of July 26, 2016 Meeting "for possible action".

VI. ADMINISTRATIVE REPORT

VII. ADMINISTRATOR LICENSES ISSUED MUST RECEIVE FINAL BOARD APPROVAL WHEN ALL REQUIREMENTS HAVE BEEN MET.

a. Nursing Facility Administrator Licenses Issued "for possible action".
(1) Sahar, Etay Y.
(2) Walker, Sean G.
(3) Perlman, Scott E.
(4) Smith, Frederick D.
(5) Nicholas, Christopher B.
(6) Perry, Reed S.

b. Residential Facility Administrator Licenses Issued "for possible action".
(1) Doyle, Maria Lauren C.
(2) Hernandez, Sheila K.
(3) Macandog, Naomi R.
(4) Loi, Volha

c. Inactive Requests "for possible action".
(1) Antonio, Margie - RFA
(2) Glum, Derrick - NFA
(3) Abdouch, Donald - NFA
(4) Donohue, Seiglinde - RFA
(5) Pike, Eric – NFA
(6) Obena, Nelson - RFA

VIII. UNFINISHED BUSINESS:

a. RCAL AIT Program Reports "for possible action"
b. NFA Report "for possible action"
c. Sophia Long – FARB Reimbursement "for possible action"

IX. NEW BUSINESS:

X. DEPUTY ATTORNEY GENERAL'S REPORT

XI. BOARD MEMBER COMMENTS

XII. PUBLIC COMMENTS

This item is to receive comments, limited to five (5) minutes, on any issue and any discussion of those items. However, no action will be taken on an item raised during Public Comments. Comments based on viewpoint are welcome.

XIII. TIME/DATE/LOCATION OF NEXT REGULAR QUARTERLY MEETING(S) "for possible action"

XIV. ADJOURNMENT

**Pursuant to NRS 241.030(1), The Nevada State Board of Examiners for Long Term Care Administrators may conduct a closed meeting to consider the character, allegations of misconduct, professional competence, or physical and mental health of a person.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary please notify the Board of Examiners for Long Term Care Administrators by calling the Board Office at 702-486-5445, or by e-mail at: beltca@beltca.nv.gov.

Anyone desiring additional information regarding the meeting, including information on how to obtain supporting board meeting material is invited to call Sandy Lampert, Executive Director, at (702) 486-5445.

Copies of BELTCA's Meeting Minutes are available at no charge at BELTCA's web site at:
beltca.nv.gov

The Agenda was posted at the following locations:
BELTCA'S website: www.beltca.nv.gov

Grant Sawyer State Office Building
555 East Washington Ave.
Las Vegas, NV 89101
Fax: 702-486-2012

ADSD
3416 Goni Rd., Building – D 132
Carson City, NV 89706
Fax: 775-687-0574

ADSD
1860 East Sahara Ave.
Las Vegas, NV 89104
Fax: 702-486-3572

DPBH
727 Fairview Dr., Suite E
Carson City, NV 89706
Fax: 775-684-1073

DPBH
4220 S. Maryland Pkwy.
Suite 810, Bldg. D
Las Vegas, NV 89119
Fax: 702-486-6520

ADSD
445 Apple Street
Reno, NV 89502
Fax: 775-688-2969

Public Library
Sierra View Branch
Fax 775-827-8792

Carson City Courthouse
100 Stewart St.
Carson City, NV 89701
Fax: 775-887-2146

Clark County – Las Vegas Library
732 North Las Vegas Blvd.
Las Vegas, NV 89101
Fax: 702-507-3598

By E-Mail

Sue Levinsky, ADSD, LV
Paul Shubert, DPBH, LV
Carrie Embree, ADSD
Charles Perry
Jennifer Williams-Woods - ADSD
Theresa Brushfield
Susan Magluilo, Administrator
Minou Nelson, DPBH
Amir Bringard, DPBH

Jill Berntson, ADSD, Reno
Teresa Stricker, ADSD, LV
E. Beck (Grant Sawyer State Office Bldg)
Daniel Mathis
Shawn McGivney
Mark McBride
Donald Sampson, DPBH, LV
Blayne Osborn, NRHP

2

BEFORE THE NEVADA STATE BOARD OF EXAMINERS

FOR LONG TERM CARE ADMINISTRATORS

In the Matter of the Complaint for Disciplinary Action Against PRESCILA BARCELON, RESPONDENT Residential Facility Administrator for ST JEAN SENIOR CARE	Case No. B-36116 B-36117 Filed: _____ _____ Executive Secretary

STIPULATION FOR SETTLEMENT

WHEREAS, as more fully addressed below, the NEVADA STATE BOARD OF EXAMINERS OF LONG TERM CARE ADMINISTRATORS, ("BOARD"), and RESPONDENT PRESCILA BARCELON ("RESPONDENT" or "BARCELON") (collectively referred to as "the Parties"), hereby enter into this Stipulation for Settlement as follows:

Jurisdiction

1. Pursuant to Nevada Revised Statute 654.110(1)(f), the BOARD has jurisdiction to receive, investigate and take appropriate action with respect to any charge or complaint filed with the BOARD against a licensee.
2. RESPONDENT at all times relevant hereto, was and currently is, licensed in the State of Nevada as a residential facility administrator ("RFA") by the BOARD, pursuant to the provisions of Nevada Revised Statutes and Nevada Administrative Code chapters 654.
3. At all times relevant hereto, RESPONDENT was the Administrator of ST. JEAN SENIOR CARE located at 6924 Acoma Court, Las Vegas, Nevada 89145, ("the

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Facility"), License No. 5742, and as a result of such licensure, her conduct in the capacity of a licensee was and is governed by Nevada Revised Statutes ("NRS") Chapter 654, Nevada Administrative Code ("NAC") 654, and other provisions of Nevada law.

4. Pursuant to Nevada Revised Statute 233B.121(5), the BOARD is authorized to enter into a settlement agreement to resolve a disputed matter.

Allegations

5. On or about February 19, 2015, the State of Nevada, Division of Public and Behavioral Health ("DPBH") conducted an annual Sate Licensure survey and initiated a complaint investigation; four complaints were substantiated. The Facility received a D grade. Subsequently DPBH issued its Statement of Deficiencies ("SOD") against the Facility.

6. On or about March 5, 2015, the State of Nevada the State of Nevada, Division of Public and Behavioral Health ("DPBH") conducted an annual Sate Licensure survey and initiated a complaint investigation; one complaint was substantiated. The Facility received a D grade. Subsequently DPBH issued its Statement of Deficiencies ("SOD") against the Facility.

7. On or about March 30, 2015, the State of Nevada the State of Nevada, Division of Public and Behavioral Health ("DPBH") conducted an annual Sate Licensure survey and initiated a complaint investigation; one complaint was substantiated. The Facility received a D grade. Subsequently DPBH issued its Statement of Deficiencies ("SOD") against the Facility.

8. On or about April 5, 2016, the BOARD filed a complaint against RESPONDENT, by certified mail, notifying RESPONDENT that sufficient evidence had been found for disciplinary action to be commenced and that the BOARD proposed such action

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

would be brought for an administrative hearing.

9. RESPONDENT acknowledges that information has been received by the BOARD or its agent, which constitutes sufficient grounds for the initiation of an administrative hearing.

Settlement

10. The Parties desire to resolve any disputed matters relating to the BOARD'S investigation, and recognize that continued litigation of this dispute would be protracted, costly and time consuming, and therefore, the Parties have reached a settlement agreement in the interest of judicial and administrative economy.

11. RESPONDENT has elected to enter into this settlement agreement rather than face the possibility of further disciplinary action by the BOARD if the BOARD were to prevail at a disciplinary hearing.

Administrative Penalty

12. RESPONDENT shall maintain a grade of B or better for all her facilities for the next twelve (12) months following the Effective Date of the BOARD's final order, and agrees that if the facility receives a grade below a B, her license shall be immediately suspended until she comes before the Board at the next Quarterly Board Meeting and pursuant to NRS 233B, the BOARD may take disciplinary action against RESPONDENT.

13. RESPONDENT shall complete Modules 1 and 4 of the Nevada Best Practices Training to be provided by the BOARD within thirty (30) days after the Effective Date of the BOARD's final order.

14. RESPONDENT shall be placed on PROBATION for a period of (12) months following the Effective Date of the BOARD's final order. Any time that RESPONDENT is unemployed or not employed as an Administrator shall not count

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

toward the probation period.

15. RESPONDENT shall pay the following monetary assessment to the BOARD:

Administrative Fine:	$1,500.00
Legal costs:	$ 3,485.06
Administrative Costs:	$ 375.00
Total Assessed	$5,360.06

16. RESPONDENT shall pay to the BOARD the total sum $5,360.06 and shall be due within thirty (30) days after the Effective Date of the BOARD's final order, otherwise, RESPONDENT is in default. RESPONDENT may immediately request a payment plan from the Executive Secretary PRIOR to default which will consist of ten percent (10%) of the balance being due within thirty (30) days after the Effective Date of the BOARD's final order and subsequent equal monthly payments as determined by the Executive Secretary.

17. If RESPONDENT requests a payment plan, any missed payments shall be considered default.

18. In the event of default, **RESPONDENT agrees that her license shall be immediately suspended.** The suspension of RESPONDENT'S license shall continue until the unpaid balance is paid in full and until the training is completed in full. RESPONDENT acknowledges that if her license is suspended, the suspension is subject to reporting to all appropriate agencies and becomes part of her permanent record.

19. RESPONDENT acknowledges that the BOARD has the legal power and authority to take action against her, including instituting debt collection actions for unpaid monetary assessments in this case.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Complete Agreement

35. This settlement agreement consists of nine pages and embodies the entire agreement between the BOARD and RESPONDENT. It may not be altered, amended or modified without the express consent of the parties.

Date: _____

By: Prescila Barcelon
Prescila Barcelon

Date: _____
NEVADA STATE BOARD OF EXAMINERS OF LONG TERM CARE ADMINISTRATORS

By: _____
Terry Clodt
Investigating Board Member

Approved as to form and content:
LAW OFFICE OF DAN M. WINDER, P.C.

_____
Arnold Weinstock, Esq.
3507 West Charleston Blvd.
Las Vegas, NV 89102
Phone: 702.474.0523
Fax: 702.474.0631

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**6/23/2016**
Case No.:	**B-36144**
Administrator:	**Belinda Devano**
License No.	**RFA 9262**
Admin of Record:	**5/20/11 to present**
Referral from:	**DPBH**
Survey Date:	**4/14/2016**
Survey due to:	**Complaint Invesigation**
Facility:	**Life Share Care Home Nevada Inc** **7925 W. Rosada Way** **Las Vegas 89149**
Number of Beds:	**8**

PROPOSED DISCIPLINE

Fine:	$ **2,000.00**
Admin Cost:	**375.00**
Training Cost:	**100.00**
Training:	**Best Practices Modules 1 and 4** **8 hours of Medication Training**

Y 515 NAC 449.259(1)(a) Supervision of Residents

Based on observation, interview and record review, the facility failed to provide protective supervision to 1 of 7 residents (Resident #7)

.

Resident #7 was admitted to the facility on 8/31/13 with a diagnosis of psychosis and depression.

On 4/14/16 at 11:45 AM, a review of Resident #7's file revealed a facility policy in the resident's admission agreement signed and dated 8/31/13 documented, "Protective supervision will be provided for resident at all times." The resident's file documented an incident report dated 3/7/16 regarding elopement. The report documented the caregiver found the resident was missing when they checked on the resident at 4:45 AM. The report documented the resident was found on the neighbor's driveway on 3/7/16 at 6:50 AM.

On 4/14/16 at 10:30 AM, upon entry to the facility Caregiver #1 was asked to turn on the front door alarm. The caregiver was unable to get the alarm to work and called the Administrator for assistance. While on the phone with the Administrator, observed the caregiver changing the batteries in the front door alarm. When the caregiver got off the phone, the caregiver reported they had to change the batteries and it was now working. On 4/15/16 at 1:20 PM, a phone interview with the Administrator revealed the resident's daughter found the resident on the neighbor's driveway. The Administrator reported they were told the resident was either laying on the driveway or sitting on the driveway; however, could not remember which one. The was sent to the hospital due to having bruises on their leg and on the bridge of their nose. The Administrator reported it was their policy to turn on the front door alarm at night; however, believed the battery in the alarm was not working at the time of the incident.

Severity:3 Scope:1

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

Based on record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 5 of 6 MARs reviewed (Resident #1, #2 #3, #4, and #5).

On 4/14/16 at 10:30 AM, a review of resident MARs revealed the following:

- Resident #1 MAR was not initialed as given for Tylenol 325 milligrams (mg) at 8:00 PM on 4/13/16.

- Resident #4's MAR was not initialed as given for Carb/Levo 25-100 mg at 8:00 PM on 3/14/16 and at 8:00 AM on 3/31/16 and Vitamin D3, DOK 100 mg, Risperidone 0.25 mg, Furosemide 20 mg, and Pot Chloride 10 milliequivilant (meq) at 8:00 AM on 3/31/16.

On 4/14/16 at 11:30 AM, Caregiver #1 acknowledged the findings.

On 3/9/16, a review of resident MARs by Aging and Disability Services Division revealed the following:

Resident #2's MAR was not initialed as given for Levetiracetam 1000 mg at 8:00 PM on 12/3/15 and Advair 250/50 MIS, Artificial Tears, Carb/Levo 10-100 mg, and DOK 100 mg at 8:00 PM on 2/29/16.

Resident #5's MAR was not initialed as given for Pravastatin 20 mg at 8:00 PM on 2/29/16 and 3/7/16, Namenda 10 mg at 5:00 PM on 2/29/16, Donepezil 10 mg at 5:00 PM on 3/7/16, Fexofenadine 180 mg, Fluticasone 50 micrograms (mcg), Vitamin D3 2000 Unit at 8:00 AM on 3/8/16, and Levothyroxin 25 mcg at 6:00 AM on 3/8/16.

On 3/9/16, Caregiver #2 reported they believed the medication was given.

This was a repeat deficiency from the 8/4/15 State Licensure survey.

Severity: 1 Scope: 3

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**6/3/2016**
Case No.:	**B-36143**
Administrator:	**Hermando M. Esguerra**
License No.	**RFA 9023**
Admin of Record:	**8/8/02 to present**
Referral from:	**DPBH**
Survey Date:	**4/22/2016**
Survey due to:	**Complaint Invesigation**
Facility:	**Angel Prestige** **3712 Spitze Dr.** **Las Vegas 89103**
Number of Beds:	**10**

PROPOSED DISCIPLINE

Fine:	$ **300.00**
Admin Cost:	**375.00**
Training Cost:	**100.00**
Training:	**Best Practices Modules 1 & 4**

DATE OF SURVEY 04/22/2016

074 NRS 449.093 Elder Abuse Training

Based on record review and interview, the facility failed to ensure 1 of 4 employees received training to recognize and prevent the abuse of older persons (Employee #1).

On 4/22/16, a review of employee files revealed the following:

- Employee #1 was hired as the Administrator on 7/15/02. The file contained evidence of elder abuse training completed on 3/24/14 and 3/14/15. The file lacked documented evidence of elder abuse training for 2016.

On 4/22/16 at 4:05 PM, Employee #3 acknowledged the missing training.

Severity:2 Scope:2

.....

Y 580 449.2 449.267(9) Money and Property of Residents

Based on interview, the facility failed to ensure an employee did not borrow money from 1 of 7 residents (Resident #1). Reference TAG Y590.

On 4/22/16 at 2:55 PM, Employee #3 admitted they borrowed $300 from Resident #1 in January 2016. The employee explained the resident cash advanced the money from their credit card and gave it to the employee.

Severity:2 Scope:1

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

Based on observations, record review and interview, the Administrator failed to ensure a resident was not financially exploited by a member of the staff (Resident #1).

On 4/22/16 in the afternoon, observations of the facility revealed the Resident #1 was no longer living in the facility.

On 4/22/16 in the afternoon, a review of Resident #1's file revealed the resident was admitted to the facility on 9/24/09. A physical examination dated 7/16/13 documented the resident was diagnosed with schizoaffective disorder. A recent physical examination dated 3/11/16 documented the resident was diagnosed with bipolar disorder, anxiety disorder, depression, insomnia, hypertension and benign prostatic hyperplasia.

Resident #1's Admission Agreement, dated 9/24/09, read, in part:

...Loss Prevention Policy:...When this facility has reason to believe resident property with a current value of one hundred ($100) or more has been stolen, the administrator shall notify in writing the appropriate law enforcement agency within 36 hours of the discovery of the alleged theft ...Resident Care Policy: All residents and staff are oriented to the Resident's Bill of Rights in order to protect the rights of residents to ensure their rights are not violated by anyone. The Administrator/Designee is responsible for the quality of care that is provided to the residents ...Financial and Monetary Supervision and Assistance Policy:...A written request by the resident or his representative requesting assistance in handling his/her monies is required. All money in excess of $100 must be maintained in a financial institution in an account separate from the facility's operating account.

Resident #1's Authorization To Handle Monthly Stipend form, dated 9/24/09 documented the resident authorized the facility to handle their monthly stipend only. The authorization did not include permission for the facility to handle any of the resident's other funds.

On 4/22/16 in the afternoon, a review of employee files revealed the following: - Employee #1, the Administrator, had elder abuse training on 3/14/15. The file lacked documented evidence of current elder abuse training.

- Employee #2, the House Manager, had elder abuse training on 3/23/16.

- Employee #3 had elder abuse training on 7/14/15.

On 4/22/16 in the afternoon, review of available facility records revealed a lack of documented evidence the facility had conducted an investigation into the allegation an employee had misused resident funds.

On 4/22/16 at 1:20 PM, Employee #3 called the House Manager and was told the House Manager would come to the facility while the inspectors were on-site. The inspectors were on-site from 1:15 PM to 4:45 PM. The House Manager did not come to the facility while the inspectors were on-site. Employee #3 also called the Administrator, however there was no answer.

On 4/22/16 at 2:55 PM, Employee #3 provided the following information:

- In approximately July, 2015, Employee #3 used Resident #1's name, personal information, and good credit history to open an internet service account. The employee contacted the internet service provider by phone to establish service in the resident's name, explaining the resident did not speak English very well. The resident wished to establish internet service as they were interested in buying a computer, however the resident did not end up purchasing a computer. The bills went to the resident, who then gave them to the employee to pay. The employee admitted the internet service account went into default for non-payment approximately one to two months after the account was established. - In approximately October, 2015, Employee #3 paid Resident #1 the amount of $100 for the use of the resident's name, personal information, and good credit history in order to open and establish a cell phone service account with a recurring monthly service fee. Additionally, the employee purchased a cell phone for approximately $800, which was charged to the account the employee opened in Resident #1's name. The employee took the resident to the cell service provider's store to open the account in the resident's name and make the phone purchase with the intent of the cell phone and account to be used solely by the employee and for the employee's benefit.

-In approximately January, 2016, Employee #3 borrowed $300 from Resident #1. The employee explained the resident cash advanced the money from their credit card and gave it to the employee. The employee told the resident their mother was sick and they needed the money to help her.

Employee #3 further explained the House Manager and Administrator were not aware of the employee's misuse of the resident of concern's funds. The employee reported, upon learning of Employee #3's misuse of resident funds, the House Manager relocated the employee to work at the manager's other group home until the resident of concern was discharged. Upon the resident's discharge, Employee #3 returned to work at the facility, and was working at the facility at the time of the on-site investigation.

Severity:3 Scope:1

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**8/31/2016**
Case No.:	**B-36149**
Administrator:	**Florentino T. Leanillo**
License No.	**RFA 9193**
Admin of Record:	**4/24/08 to the present**
Referral from:	**DPBH**
Survey Date:	**5/24/2016**
Survey due to:	**Annual State Licensure Survey & Complaint Investigation**
Facility:	**Family Home Care RHL LLC 975 Cordone Ave. Reno 89502**
Number of Beds:	**9**

PROPOSED DISCIPLINE

Fine:	$ **3,000.00**
Admin Cost:	**375.00**
Training Cost:	**250.00**
Training:	**Best Practices Modules 1, 3, 4, 7 & 8 and 8 hrs Medication Training**

Summary of BELTCA reviewer:
DATE 08/31//2016

Y 088 NAC 449 3199(4) Staffing Schedule.

Based on document review and interview, the administrator failed to maintain a monthly staffing schedule for at least six months.

On 2/4/16 at 2:15 PM, during the complaint investigation staffing schedules were requested . The staffing schedules for September, October, November and December 2015 and January and February 2016 were unavailable.

On 2/4/16 at 2:15 PM, Employee #2 confirmed there were no staffing schedules.

Severity: 1 Scope: 3

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

Based on record review and interview, the facility failed to ensure 2 of 4 employees met the requirements concerning tuberculosis (TB) testing and pre-employment physical examination. (Employee #3 and #4).

Employee #3 was hired on 7/3/14. On 2/4/16 in the morning, the employee file revealed documented evidence of a physical examination dated 12/5/14, five months after the hire date.

Employee #4 was hired on 1/11/13. On 2/4/16 in the morning, the employee file revealed documented evidence of a positive TB test dated 2/6/13, and a negative chest x-ray dated 2/8/13. The employee file lacked documented evidence of annual 2014 and 2015 signs and symptoms reviews.

On 2/4/16 in the afternoon, Employee #2 confirmed the deficiencies.

Severity:2 Scope:3

Y 170 NAC 449.209(1)(a) Health and Sanitation-Safe water. and sewage

Based on observation and interview, the facility failed to maintain an adequate system for the disposal of sewage.

On 2/4/16 in the morning, during a tour of the facility observed a sign in two resident bathrooms that read, "Please "no" toilet paper "no" paper towel in the bowl.

On 2/4/16 in the afternoon, Employee #2 confirmed they requested no one flush anything down the toilet because they clog easily but acknowledged that disposing of human waste in the bathroom trash can was unsanitary.

Severity: 2 Scope: 3

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

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

On 2/4/16 in the morning, during a tour of the facility observed the following:

-The light in the bathroom by Room #5 had a thick layer of dirt on the front and bottom of the light cover

-A white minivan was observed parked in the front yard. The license tabs expired December 2014. -Miscellaneous buckets, tools, paint can and clothes baskets were in the backyard on the side of the house

-There was a dark layer of grease and grime under the stove hood in the kitchen

-The inside oven door was dirty with grease in the kitchen

-The wall behind the stove in the kitchen had a layer of grease on it

-The lint trap had a layer of lint in it

On 2/4/16 in the morning, Employee #2 confirmed the observations. Employee #1 acknowledged the minivan was inoperable, indicating it had been given to someone who needed to tow the vehicle away.

Severity: 2 Scope: 3

Y 356 NAC 449.222(6) Bathrooms and Toilet Facilities

Based on observation and interview, the facility failed to ensure the locks on 1 of 2 bathroom doors could be opened with a single motion (Bathroom next to linen closet).

On 2/4/16 at 2:00 PM, observed the bathroom located by the linen closet had a double motion lock on it.

On 2/4/16 in the afternoon, Employee #1 and #2 confirmed the observation and acknowledged the potential harm.

Severity:2 Scope: 3

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

Based on observation and interview, the facility failed to ensure 2 out of 2 fire extinguishers were inspected annually. State Fire Marshall referral

On 2/4/16 in the morning, during a tour of the facility observed two fire extinguishers tagged with an inspection date of 1/29/15.

On 2/4/16 in the morning, Employee #1 confirmed the date of the last inspection.

NO RATING

Y 565 NAC 449.267(1) Money and Property of Residents

Based on document review, record review and interview, the facility failed to ensure employees obtained a written request for a resident or their representative to handle the resident's money (Resident #2 and #9).

-Resident #2 was admitted on 9/26/13 with primary diagnoses of dementia, hypertension and hearing loss. On 2/4/16 in the afternoon, review of the resident file revealed a 55+ inch television was purchased for Resident #2 on 12/18/14 for $521.00, and a recliner purchased for Resident #2 on 3/11/15 for $296.00. There was no documented evidence of receipts and/or a request or permission to purchase the items by the resident.

On 2/4/16 at 12:10 PM, Employee #2 (the Owner) indicated they were told by the payee to buy Resident #2 whatever they wanted to get their total assets under

$2,000.00 to qualify for Medicaid. Employee #2 reported the resident's social worker was aware of this information.

On 2/4/16 in the afternoon, an observation of the bedroom for Resident #2 revealed neither the television nor recliner were in the resident's bedroom. The television was observed in the common area living room and was on at the time of observation. The red leather recliner was observed in Bedroom #2 with another resident.

On 2/4/16 at 12:15 PM, Employee #2 reported the television was in the living room but Resident #2 was the only resident to watch it. Employee #2 reported the recliner was in another bedroom because it did not fit in Resident #2's bedroom.

On 2/4/16 in the afternoon, attempts to interview Resident #2 were unsuccessful. The resident was asleep during the entire time of the survey. At the time of survey, the resident was 102 years old.

On 3/29/16 at 1:00 PM, the payee for Resident #2 reported they began representing the resident in March 2014. The payee confirmed they told the facility to make sure to keep the resident's assets under $2,000.00 per month in order to apply for Medicaid. The payee confirmed they have nothing in writing or an agreement with the resident to purchase items and indicated they only get the receipts from the facility and reimburses the facility for the expense. The payee reported if they receive receipts, no further questions are asked and the request is paid. The payee confirmed they have no authority to spend client money with no agreement. The payee indicated there was no communication with a social worker, family member or power of attorney and that if the resident had a power of attorney, they would not need a payee.

On 5/23/16 in the afternoon, review of the Client Transactions by Client document provided by the payee for the dates between 3/3/14 and 4/1/16 revealed several payments payable to the facility for Resident #2 labeled miscellaneous or personal needs. Personal needs checks had been payable to Resident #2 until 8/22/14. All monthly personal needs payments for Resident #2 between 10/20/14 and 1/20/15 were payable to the facility. These transactions were not documented in the resident's file.

The facility failed to ensure a written request was obtained from the resident to handle the money for Resident #2. See TAGs Y566 and Y590.

-Resident #9 was admitted on 4/21/15 with primary diagnoses of dementia with behavioral problems, probable Alzheimer's type with hallucinations and delusions. On 4/23/15, the facility documented Activities of Daily Living (ADLs) needs as: all areas assisted with the exception of feeding (independent) and laundry and medications (dependent). The document was completed with the areas of resident oriented, resident follows instructions and resident makes needs known as "not all the time."

On 2/4/16 in the morning, review of the resident record revealed on 11/3/15, Resident #9

was taking the following medications: Depakote, Vitamin D2, Tolterodine, Divalproex, Vitamin B12, Aricept and PreserVision.

On 5/9/16 in the morning, review of the General Durable Power of Attorney given by Resident #9 dated 7/2/05 read, in part, "...2. General Powers to Manage Assets...2.1 To make, do and transact business of any kind or class, including the receipt, recovery, collection, payment, compromise, settlement and adjustment of all accounts, legacies, bequests, interests, dividends, annuities, demands, debts, taxes and obligations...2.2 To deposit and withdraw in or from any banking institution, in my name or in the name of my Agent, any funds, negotiable paper, monies or other credits which I now or hereafter may have on deposit or be entitled to, and to make, endorse, cash and receive the proceeds of any or all checks, vouchers or other negotiable instruments..." The document became effective on disability or incapacity as documented by Resident #9's physician on 4/15/15. The agent and successor agents were friends of the family who cared for the resident for many years prior to placement into the facility.

On 5/9/16 in the morning, review of the physician letter stating disability or incapacity for Resident #9 read, in part, "...[resident] does not understand their medical care needs or financial matters. [Resident] does not have capacity to make rational decisions regarding [resident] personal affairs..."

On 5/9/16 in the morning, review of the Physician's Certificate with Needs Assessment dated 4/14/15, provided supporting documentation for Resident #9's disability or incapacity and read, in part, "...I certify that this adult patient is unable to respond to a substantial and immediate risk of financial loss...My opinion of the patient's mental capacity and/or ability to function independently without assistance of others is poor...My opinion as to the patient's everyday functions is as follows:...Financial: Manage and use checks, deposit, withdraw, dispose, invest monetary assets = total care; Enter into a contract, financial commitment, or lease arrangement = total care; and resist exploitation, coercion, undue influence = total care...My opinion as to the patient's need for a guardian is as follows: The patient needs a guardian of the person and estate to make medical and financial decisions..."

On 2/4/16 in the afternoon, review of the record for Resident #9 revealed a letter dated 4/24/15 from the resident's general power of attorney/agent resigning and relinquishing control to the named successor agent. There was no further power of attorney documentation after 4/24/15 in the resident file regarding the two named successor agents. The agent and successor agents were friends of the family who cared for the resident for many years prior to placement into the facility.

On 2/4/16 at 12:30 PM, Employee #2 reported the power of attorney resigned and the Ombudsman recommended a payee be assigned. A payee was assigned and per advice of the social worker, the facility initiated the change of payee. The Social Security Administration chose a new payee on 8/26/15. There was no documented evidence the successor power of attorney was notified of the change. Employee #2

reported their agreement with Resident #9 was for payment of $1,891.00 per month, the same amount as the resident's monthly Social Security checks. The resident was supposed to receive $112 a month for personal needs. On 2/4/16 in the afternoon, review of the facility money management log for Resident #9 revealed three entries reflecting cash deposits and withdrawals as follows: 6/22/15 deposit and withdrawal of $112.00, 7/2/15 deposit and withdrawal of $100.00 and 8/13/15 deposit and withdrawal of $120.00, leaving a zero balance each transaction. There were no obvious signatures or initials on the document of what employee documented the transactions.

On 2/4/16 in the afternoon, review of the file for Resident #9 revealed a handwritten note (unknown who wrote the note) dated 9/16/15 and signed by the resident canceling all life insurance policies. A letter dated 10/5/15 acknowledged a request to cancel a life insurance policy with their agency. The letter indicated a current cash value of $760.34. There was a handwritten note on the top of the letter (unknown who wrote the note) dated 10/13/15 8:45 AM, indicating someone spoke with a representative regarding the cancellation check. According to a handwritten note (unknown who wrote the note), the check was mailed on 10/16/15, however a letter from the insurance agency dated 10/28/15 spoke to the power of attorney/agent not having authorization over insurance transactions and unless updated information giving specific authority over insurance transactions was received, the agency would not accept written or verbal requests from Resident #9.

On 2/4/16 in the afternoon, the file for Resident #9 revealed a copy of a check stub dated 11/9/15 in the name of the resident and mailed to the facility address in the amount of $760.34. The file contained a copy of a bank deposit slip receipt for the same amount dated 11/17/15.

On 2/4/16 at 12:55 PM, an interview with Resident #6 revealed Resident #9 canceled their life insurance policy by phone with their assistance because there was no family and the resident was hard of hearing. The insurance agency sent the check to Resident #9 and Employee #1 (the Administrator) took Resident #9 to cash the check received. Resident #6 indicated Resident #9 demanded the check be sent to them and Resident #9 did not have a checkbook on site. Resident #6 reported they helped Resident #9 all of the time and handled their money, took them shopping for shoes, clothes, lots of candy and snack from places like a department store and homeless rescue organization (unknown amount). Resident #6 reported Resident #9 had no money when they died, having no more than $20.00 in their room when they went to the hospital. The resident file lacked documentation for any of the expenditures.

Resident #9 was admitted to the hospital on 12/4/15 and died on 12/6/15.

On 3/29/16 at 1:00 PM, an interview with a representative of Resident #9's new payee of record revealed their agency began providing services to Resident #9 in September 2015. The representative indicated the facility decided to change the payee for Resident #9 due

to On 2/4/16 in the afternoon, review of the record for Resident #9 revealed a letter dated 4/24/15 from the resident's general power of attorney/agent resigning and relinquishing control to the named successor agent. There was no further power of attorney documentation after 4/24/15 in the resident file regarding the two named successor agents. The agent and successor agents were friends of the family who cared for the resident for many years prior to placement into the facility.

On 2/4/16 at 12:30 PM, Employee #2 reported the power of attorney resigned and the Ombudsman recommended a payee be assigned. A payee was assigned and per advice of the social worker, the facility initiated the change of payee. The Social Security Administration chose a new payee on 8/26/15. There was no documented evidence the successor power of attorney was notified of the change. Employee #2 reported their agreement with Resident #9 was for payment of $1,891.00 per month, the same amount as the resident's monthly Social Security checks. The resident was supposed to receive $112 a month for personal needs. On 2/4/16 in the afternoon, review of the facility money management log for Resident #9 revealed three entries reflecting cash deposits and withdrawals as follows: 6/22/15 deposit and withdrawal of $112.00, 7/2/15 deposit and withdrawal of $100.00 and 8/13/15 deposit and withdrawal of $120.00, leaving a zero balance each transaction. There were no obvious signatures or initials on the document of what employee documented the transactions.

On 2/4/16 in the afternoon, review of the file for Resident #9 revealed a handwritten note (unknown who wrote the note) dated 9/16/15 and signed by the resident canceling all life insurance policies. A letter dated 10/5/15 acknowledged a request to cancel a life insurance policy with their agency. The letter indicated a current cash value of $760.34. There was a handwritten note on the top of the letter (unknown who wrote the note) dated 10/13/15 8:45 AM, indicating someone spoke with a representative regarding the cancellation check. According to a handwritten note (unknown who wrote the note), the check was mailed on 10/16/15, however a letter from the insurance agency dated 10/28/15 spoke to the power of attorney/agent not having authorization over insurance transactions and unless updated information giving specific authority over insurance transactions was received, the agency would not accept written or verbal requests from Resident #9.

On 2/4/16 in the afternoon, the file for Resident #9 revealed a copy of a check stub dated 11/9/15 in the name of the resident and mailed to the facility address in the amount of $760.34. The file contained a copy of a bank deposit slip receipt for the same amount dated 11/17/15.

On 2/4/16 at 12:55 PM, an interview with Resident #6 revealed Resident #9 canceled their life insurance policy by phone with their assistance because there was no family and the resident was hard of hearing. The insurance agency sent the check to Resident #9 and Employee #1 (the Administrator) took Resident #9 to cash the check received. Resident #6 indicated Resident #9 demanded the check be sent to them and Resident #9 did not have a checkbook on site. Resident #6 reported they helped Resident #9 all of the time

and handled their money, took them shopping for shoes, clothes, lots of candy and snack from places like a department store and homeless rescue organization (unknown amount). Resident #6 reported Resident #9 had no money when they died, having no more than $20.00 in their room when they went to the hospital. The resident file lacked documentation for any of the expenditures.

Resident #9 was admitted to the hospital on 12/4/15 and died on 12/6/15.

On 3/29/16 at 1:00 PM, an interview with a representative of Resident #9's new payee of record revealed their agency began providing services to Resident #9 in September 2015. The representative indicated the facility decided to change the payee for Resident #9 due to unhappiness with the prior payee. The payee, Resident #9 and an employee of the facility went to the Social Security Administration office to change payees. The payee reported the resident was not given personal money monthly because there was not enough money, however the resident received $60.00 on 11/25/15. There was no documented evidence this transaction was documented by the facility on the Money Management Log for Resident #9.

On 3/29/16 at 1:00 PM, the payee representative reported their responsibility was to make sure bills were paid. There was no written agreement with Resident #9. There was no communication with the resident's social worker, family members or power of attorney. If the resident had a power of attorney, the payee was not needed. The payee indicated they only communicated with Employee #2. The payee conducted a site visit to the facility in December 2015 but only to see if the client was okay, nothing more. The payee reported they had no knowledge of the resident canceling any policies, checks being sent and cashed and no knowledge of what was done with the $760.34.
The payee was the payee of record when the insurance policy was canceled.

The facility failed to follow proper practices in handling the financial affairs for Resident #9. See TAGs Y566 and Y590.

Severity: 2 Scope: 2

Complaint #NV00044887

Y 566 NAC 449.267(2)(a)-(c) Money and Property of Residents

Based on observation, record review and interview, the facility failed to keep accurate records of financial transactions by the facility for 2 of 8 residents (Resident #2 and #9).

-Resident #2 was admitted on 9/26/13 with primary diagnoses of dementia, hypertension and hearing loss. On 2/4/16 in the afternoon, review of the resident file revealed a 55+ inch television was purchased for Resident #2 on 12/18/14 for $521.00, and a recliner purchased for Resident #2 on 3/11/15 for $296.00. There was no documented evidence

of receipts and/or a request or permission to purchase the items by the resident.

On 2/4/16 in the afternoon, attempts to interview Resident #2 were unsuccessful. The resident was asleep during the entire time of the survey.

At the time of survey, the resident was 102 years old.

On 3/29/16 at 1:00 PM, the payee for Resident #2 reported they began representing the resident in March 2014.

On 5/23/16 in the afternoon, review of the Client Transactions by Client document provided by the payee for the dates between 3/3/14 and 4/1/16 revealed several payments payable to the facility for Resident #2 labeled miscellaneous or personal needs. Personal needs checks had been payable to Resident #2 until 8/22/14. All monthly personal needs payments for Resident #2 between 10/2014 and 1/2015 were payable to the facility. These transactions were not documented in the resident's file.

The facility failed to ensure all financial transactions for Resident #2 were properly documented.

-Resident #9 was admitted on 4/21/15 with primary diagnoses of dementia with behavioral problems, probable Alzheimer's type with hallucinations and delusions.

On 3/29/16 at 1:00 PM, an interview with a representative of Resident #9's new payee of record revealed their agency began providing services to Resident #9 in September 2015. The payee reported the resident was not given personal money monthly because there was not enough money, however the resident received $60.00 on 11/25/15. There was no documented evidence this transaction on the Money Management Log for Resident #9.

On 3/29/16 at 1:00 PM, the payee representative reported there was no written agreement with Resident #9. The payee indicated they only communicated with Employee #2 (the Owner). The payee conducted a site visit to the facility in December 2015 but only to see if the client was okay, nothing more.

The facility failed to ensure all financial transactions for Resident #9 were properly documented.

Severity: 2 Scope: 2

Complaint #NV00044887

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

Based on document review, record review and interview, the Administrator failed to ensure 2 of 8 residents were not financially exploited (Resident #2 and #9).

-Resident #2, date of birth 2/14/1913, was admitted on 9/26/13 with primary diagnoses of dementia, hypertension and hearing loss. Between 2/4/16 and 5/23/16, review of the resident file revealed incomplete and/or missing documentation authorizing the facility employees to conduct financial transactions on their behalf. See TAGs Y565 and Y566.

Resident #9 was admitted on 4/21/15 with primary diagnosis of dementia with behavior problems. Between 2/4/16 and 5/23/16, review of the resident file revealed lack of documented evidence authorizing the facility employees and/or residents to conduct financial transactions on their behalf. See TAGs Y565 and Y566.

On 2/4/16 at 1:30 PM, review of the Resident Admission Agreement for Resident #2 and #9 revealed no information on how the resident and/or facility would handle resident money and/or financial transactions.

On 2/4/16 in the afternoon, review of the employee files revealed the following: -Employee #1 acquired elder abuse training on 2/1/15 and 1/23/16.

-Employee #2 acquired elder abuse training on 1/15/15 and 1/14/16.

-Employee #3 acquired elder abuse training on 7/3/14 and 1/18/16. The employee file lacked documented evidence of elder abuse training in 2015.

-Employee #4 acquired elder abuse training on 1/20/15 and 1/14/16.

Severity:2 Scope:2

Complaint #NV00044887

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

Based on observation, document review and interview, the facility failed to ensure medications

On 2/4/16 in the afternoon, observed the following unsecured medications:

-Room #7 - Fiber Therapy, rubbing alcohol, Tums and Vicks VapoRub

-Room #1 - Robitussin cough syrup, Caladryl and Chlorhexidine Gluconate 0.12% Oral Rinse.

There was no name on any of the observed medications with the exception of the oral rinse and it could not be confirmed if there were any physician orders for any of the medications.

On 2/4/16 in the afternoon, the facility House Rules read, in part"...6. All medications

will be placed in a locked cabinet as per requirement by the state. Incoming and outgoing medications must be logged in...7. All incoming food, gifts and over the counter medicines from the families, relatives, and friends must inform the facility."

On 2/4/16 in the afternoon, Employee #2 confirmed the observations reporting it was a struggle to keep medications out of resident rooms.

Severity: 2 Scope: 3

Y1011 NAC 449.2764(2) Mental Illness Training.

Based on record review and interview, the facility had a mental illness endorsement and failed to ensure 2 of 4 employees had received 8 hours of training concerning care for residents who are suffering from mental illnesses within 60 days of hire (Employee #3 and #4).

Employee #3 was hired on 7/3/14. On 2/4/16 in the morning, review of the employee file revealed three hours of mental illness training dated 8/9/14. Review of the employee file revealed documented evidence of additional mental illness training totaling four hours on 11/6/15 and 11/20/15, beyond the 60 days of hire. The employee file lacked documented evidence of the one remaining required mental illness training hour.

Employee #4 was hired on 1/11/13. On 2/4/16 in the morning, the employee file revealed two hours of mental illness training dated 10/5/13 and three hours of mental illness training on 10/16/14, beyond the 60 days of hire.
The employee file lacked documented evidence of the three remaining required mental illness training hours.

On 2/4/16 at 10:45 AM, Employee #2, acknowledged the missing training and indicated an unawareness of the mental illness training requirements.

Severity: 2 Scope: 3

Y1021 NAC 449.2766(2)(3) Chronic Illness Training.

Based on record review and interview, the facility had a chronic illness endorsement and failed to ensure 1 of 4 caregivers received at least 4 hours of training concerning care for residents with chronic illnesses and methods of infection control within 60 days of hire (Employee #2).

Employee #2 was hired in 2009 as the Owner/Caregiver. On 2/4/16 in the morning, the

employee file revealed two hours of chronic illness training dated 9/29/10. Two and a half additional hours of chronic illness training was acquired on 10/25/15, beyond 60 days from when the endorsement was implemented.

On 2/4/16 at 10:45 AM, Employee #2 acknowledged the deficiency indicating an unawareness of the chronic illness training requirement.

Severity:2 Scope: 1

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**9/2/2016**
Case No.:	**B-36145**
Administrator:	**Barry Wicklund**
License No.	**RFA 9301**
Admin of Record:	**9/01/12 present**
Referral from:	**DPBH**
Survey Date:	**4/11/2016**
Survey due to:	**Complaint Investigation**
Facility:	**Addie's Home Care Inc.** **7955 Trail Head Dr.** **Las Vegas 89113**
Number of Beds:	**9**

PROPOSED DISCIPLINE

Fine:	$ **750.00**
Admin Cost:	**375.00**
Training Cost:	**100.00**
Training:	**Best Practices Modules 1 & 4** **and 8 hrs Medication Training**

DATE OF SURVEY 06/24/2915

Y050 NAC 449.194(1) Administrator's -Responsibilities-Oversight

Based on observation, interview and record review, the administrator failed to provide necessary oversight to ensure residents safety See tags #671, #871, #895, #923 and #938.

Severity: 2 Scope: 3

Y 181 NAC 449.209(8) Health and Sanitation Temperature

Based on observation and interview, the facility failed to ensure the temperature was maintained
at an appropriate level in 1 out of 5 resident rooms. (Resident #11).

On 6/9/15 at 3:00 PM, Resident #1 was in bed with the bedroom door closed. The resident is bed bound. The room was 88 degrees Fahrenheit, and the resident verbalized it was warm.

On 6/9/15 at 3:25 PM, Caregiver #3 verbalized the door was kept closed because the Resident's
TV was too laud, and they closed the air vent because the resident was too cold,

Severity.2 Scope:1

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

On 619/15 at 3:00 PM, Resident #1 indicated she had only been taken out of the bedroom once. Based on observation, interview and record review, the facility failed to ensure 2 out of 5 residents were not neglected. (Resident #1 and #3).

On 619/15 at 3:00 PM, Resident #1 was in bed with the bedroom door closed. The resident was
bed bound. The room was 88 degrees Fahrenheit, and the resident verbalized it was warm.

Resident #1 indicated she did not receive a shower since prior to being admitted to the facility and wanted a shower but they only provided sponge baths. Resident #1 indicated she was paralyzed on the right side and needed a two person assist. Resident #1 explained the male caregiver was the only one who was able to transfer residents at the facilty.

On 6/9/15 at 4:15 PM, the facility Owner indicated Resident #1 has only had sponge baths because they were concerned about transferring her into the shower with the shower seat that was at the facility. The Owner indicated she was going to purchase a wheel chair that could be utilized in the shower.

On 6/9/15 at 4:15 PM, Caregiver #3 verbalized Resident #1 did not receive a shower because they did not have the proper chair.

Resident #3 was admitted with a diagnosis of morbid obesity, hypertension, diabetes type II with; renal manifestation, and dyslipidemia.

- On 6/9/15 at 4:15 PM, Caregiver #2 indicated they were unable to transfer Resident #3 who was a three to four person assist. Caregiver #2 verbalized they had to call 311 because they could not get Resident #3 up to transfer her.

- On 7/1/15, review of Resident #3's Acute Care Hospital Emergency Room Physician Record dated 6/3/15 at 4:07 PM revealed the following: Staff reported that the patient was altered, she found covered in urine in her bed. She was I bed bound secondary to a previous cerebrovascular accident with right-sided deficit-She had a strong scent of urine.

Severity: 2 Scope: 1

Y 617. NAC 449.2702(2) Admissions Policy

Based on observation, interview and record review, the facility failed to ensure residents admitted to the facility did not require a higher category of care than the facility could provide for 2 of 2 residents (Resident #1 and #3). Findings include:

Resident #1 was admitted to the facility on 5/28/15 with diagnoses to include: Urinary Tract Infection, Congestive Heart Failure, Coronary Artery Disease and Stroke with right sided paralysis.

On 6/10/15, an ADSD (Aging Disability Services Division) worker was advised by Resident #1 the facility was unable to provide a shower or take her out of her room as there is only one caregiver in the facility that is able to transfer her. On 6/10/15 at 3:00 pm, Resident #1 confirmed the conversation with ADSD. The resident did advise she had received her first shower at the facility since being admitted the evening prior "after the state came in". The resident advised the facility was unable to help her and would like to go somewhere else.

On 6/10/15 at 3:30 pm, the owner of the facility revealed, "I probably shouldn't have

admitted her (Resident #1) to begin with. I had to find help just to get her out of the car."

Resident #3 was admitted on 3/20115 with a diagnosis of morbid obesity, hypertension, diabetes type li with renal manifestation, and dislipidemia.

On 619/15 at 3:00 PM, Caregiver #3 indicated caregivers had difficulty transferring Resident #3 due to the resident having obesity and weakness. Caregiver #3 explained the resident would throw food and waste, remove briefs and scratch at her body.

On 6/9/15 at 4:20 PM, Caregiver #2 verbalized the caregivers could not transfer Resident #3 because she was a three to four person assist. Caregiver #2 explained, Resident #3 was being transferred to the bedroom but was not able to make it, the caregiver called 311 for assistance with transferring the resident.

On 6/9/15 at 4:25 PM, the facility Owner indicated when admitting Resident #3 she had difficulty transferring her from the previous facility to her car.

On 6/9/15, review of the facility incident reports revealed the following: Incident Report dated 3/20/15 indicated the caregivers had difficulty lifting Resident #3 from the floor and had to call 311 who came and provided assistance getting Resident #3 to her room.

Severity:2 Scope:2

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

Based on record review and interview, the facility failed to ensure medications were refilled in timely manner for 2 of 5 sampled residents. (Resident #1 and #2).

On 6/10/15 at 4:15 PM, review of Resident #2's Medication Administration Record (MAR) and on-site medications revealed the following: - The MAR dated June, 2015 revealed hydrocodone/ APAP 5-325 milligrams (mg) twice a day was signed as given on 6/9/15. There was no hydrocodone/APAP on-site.

- The MAR dated June, 2015 indicated Carbidopa/Levodopa extended release 200 mg. one tablet by mouth four times a day. Review of the on-site medication revealed there was one tablet left.

On 6110/15 in the evening, Caregiver#2 indicated the facility did not receive a delivery of Resident #2's hydrocodone in June, 2015,

On 6/10/15 at 4:15 PM, Resident #2's daughter indicated the resident had not taken

hydrocodone in a while.

On 6/10/15 at 7:05 AM, review of Resident #1's Medication Administration Record (MAR), on-site medications, and physician orders revealed the following:

Resident #1's physician orders dated 6/2/15 indicated Small Volume Nebulizer (SVN) machine. There was no nebulizer on-site on 6/9115.

Review of the MAR dated June, 2015 revealed ipratropium Bromide 0.5 mg and Albuterol Sulfate 3 milliliters (ML): give vial 3 ml via nebulizer every four hours was not documented as given in June, 2015

On 6/9/15 at 4:10 PM, the facility Owner indicated there was oxygen that was used for Resident #1, however it was another resident's oxygen. The Owner indicated they administered oxygen to Resident #1 for a couple of days because the resident had trouble breathing.

Severity.2 Scope: 1

Y886 NAC 449.2742(10) Medication Administration Responsibility

Based on interview and record review, the Administrator failed to ensure medication was administered in accordance with physician's orders and refilled in a timely manner for 2 out of 5 sampled residents. (Resident #1 and #2). See tags #871, #895 and #923.

Severity: 2 Scope: 2

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

Based on observation, record review and interview, the facility failed to ensure 1 out of 5 sampled residents had medications administered in accordance with physician orders. (Resident #1).

On 6/10/15 at 7:05 AM, review of Resident #1's Medication Administration Record (MAR), on-site medications, and physician orders revealed the following:

1. Resident #1's physician order dated 5129/15 indicated Coumadin 2 milligrams (mg) by mouth daily, monitor Prothrombin Time (PT) and International Normalized Ratio (INR) daily. The Medication Administration Record indicated Warfarin Sodium 1 mg by mouth every day was given, and included monitor PT/INR. The MAR dated June, 2015 inidcated Warfarin was given 6/1/15 through 6/9/15. Coumadin 2 mg (30 tablets) was delivered on 6/1/15. A pill count conducted on 6/9/15 revealed \25 pills left in the bottle.

2. Resident #1's on-site medication and MAR dated June, 2015 indicated Hydralazine 25 mg tablet, one tablet by mouth every 4 hours. Hold if Systolic Blood Pressure (SBP) is lower than 110, or heart rate lower than 60, or Diastolic Blood Pressure (DBP) lower than 65. The June, 2015 MAR revealed Hydralazine was documented as given four times a day from 6/1/15 through 6/9/15 and once on 6/10/15 in the morning.

On 6/10/15 at 7:05 AM, Resident #1 indicated she was unable to take her own blood pressure and the caregivers did not take her blood pressure.

On 6/10/15 in the mom ing, Caregiver #2 verbalized they "observed" Resident #1, but did not take her blood pressure.

On 6/10/15 at 7:15 AM, Caregiver #2 was unable to explain why the amount of pills did not match the amount of days Resident #1's Coumadin medication was documented as given.

Severity: 1 Scope: 2

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

Based on observation, document review and interview, the facility failed to ensure medication were kept in the original container.

On 61/10/15 at 2:20 pm, two plastic bags with a note attached were observed in the medication bin for Resident # 1. - Handwriting on plastic bag #1 documented: Hydralazine 25 mg (milligrams), 45 tabs (tablets; - Handwriting on plastic bag #2 documented: Warfarin 2 mg, 25 tabs.

A handwritten note, stapled to the two plastic bags indicated the medications were "left over from another bottle". A yellow sticky note attached to the bags dated 619/15, read, "(Resident #1's name). 6/9/15, over count meds"

At 2:25 pm, Caregiver ##3 explained the medications were an overage from the pharmacy The caregiver indicated he had removed the additional tablets so the count of the pills would match the amount dispensed. Caregiver # 3 indicated the pharmacy had not been notified of the overage. The caregiver explained he had been instructed at another facility to do this. The caregiver acknowledged medication training did not allow this practice and was aware that medications are to be kept in the original container.

Severity: 2 Scope: 1

Y 938 NAC 449.2749(1)(g)(1) Resident file ADL Evaluation Admission

Based on record review and interview, the facility failed to provide evidence of an evaluation of a residents ability to perform Activities of Daily Living (ADL's) for 5 out of 5 sampled residents. (Resident #1, #2, #3, #4 and #5).

On 6/09/15 in the afternoon, Resident #1, #2, # #4 and #5's records lacked documented evidence an evaluation on activities of daily living was completed upon admission of the residents.

On 6/09/15 at 5:10 PM, the facility Owner indicated they obtained a history and physical \from the hospital, and conducted an interview with each resident, however they did not document ADL evaluation.

Severity: 2 Scope: 3

PROPOSED DISCIPLINARY ACTION SUMMARY

Review Date:	**5/23/2016**
Case No.:	**B-36142**
Administrator:	**Assaad B. Zeid**
License No.	**RFA 9273**
Admin of Record:	**8/18/14 to present**
Referral from:	**DPBH**
Survey Date:	**4/19/2016**
Survey due to:	**Complaint Invesigation**
Facility:	**Morningstar of Sparks** **2360 Wingfield Hills Dr.** **Sparks 89436**
Number of Beds:	**112**

PROPOSED DISCIPLINE

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

DATE OF SURVEY 04/19/2016 Surveyor Michael Kupper at 775-684-1052.

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

Based on record review, policy review and interview, the facility failed to ensure medications were on site to administer as prescribed per physician order for 1 of 5 residents (Resident #2).

Resident #2 was admitted on 8/16/10 with diagnoses including convulsions, history of fall, anxiety, abnormality of gait, dementia with behavioral disturbance and other chronic pain.

Review of December 2015 to April 2016 Medication Administration Record (MAR) revealed:

-Mirtazapine 30 MG Tablet, take 1 tab by mouth (PO) at bedtime for appetite was not administered on 12/17/15, 12/18/15, 12/19/15 and 12/20/15. The reverse side of the MAR documented the medication was not on site for each of the four missed doses.

-Levetiracetam (Keppra) 500 MG Tab, take 1 tablet orally twice a day was not administered at 8:00 PM on 3/20/16, at 8:00 AM nor 8:00 PM on 3/21/16, at 8:00 AM nor 8:00 PM on 3/22/16 and at 8:00 AM on 3/23/16. The reverse side of the MAR documented the medication was not in because the facility was waiting on delivery. On 3/23/16 at 8:00 PM the medication was not administered due to the resident was out of the facility in the hospital. Additionally, the 8:00 AM dose on 3/24/16 was circled as not administered, however, the MAR lacked a documented reason why the medication was not administered.

Reviewed a Self Report Form the facility dated 3/31/16. This report provided evidence that Resident #2 had a seizure on 3/23/16 at 5:38 PM due to not being administered his seizure medication (Levetiracetam 500 MG) for four days.

The local Emergency Medical Service transported the resident to the hospital. Resident #2 returned from the hospital to the facility on 3/23/16.

Reviewed hospital records, which revealed Resident #2 was admitted on 3/23/16 at 6:26 PM due to a seizure. On 3/23/16 at 8:49 PM, Keppra 500 MG PO was administered to Resident #2 by the hospital staff.

Reviewed the facility's Medication Administration Policy, no date. The policy indicated:

- 1. All medications re-orders must occur 7 days prior to the resident running out. Medication Care Management team must note on the container the date of re-order.

- 2. Residents must not run out of medications.

Reviewed the facility's Pharmacy Consent signed by Resident #2's responsible party. Each resident of the facility agreed to use the facility's contracted pharmacy unless they choose to pay an additional $225.00 per month for a no-preferred pharmacy.

On 4/19/16 at 10:40 AM, the Wellness Director explained the facility is contracted with one specific pharmacy, which all of the residents utilized. She communicated the Medication Aides (MedAide) are trained to re-order resident medications 14 days prior to the last dose of medication available. However, the contracted pharmacy will not allow the facility to re-order that soon. Therefore, the MedAides will attempt to re-order per the facility's policy of seven days prior to the last dose. The Wellness Director further explained the employees still had difficulty receiving medications prior to the resident finishing their last dose. She described having made phone calls to the pharmacy as well as prescribing physician in order to have the medication onsite, however she lacked documented evidence of these phone calls nor documented evidence of any faxed transmissions. She recounted, Resident #2's medication was refilled by Employee #5 on 3/23/16 and provided this documented evidence to the inspector. The medication was delivered to the facility on 3/24/16.

On 4/19/16 at 10:49 AM, Employee #8 reported they did not follow through to make sure the medication was onsite.

On 4/19/19 in the morning, Employees #6, #7, #8 and #9 acknowledged resident medications were not delivered to the facility in a timely manner, which lead to Resident #2 not receiving medications as prescribed by his physician, which ultimately caused harm.

Severity:3 Scope:1

3

STATE OF NEVDA
BOARD OF EXAMINERS FOR LONG-TERM CARE ADMINISTRATORS

Draft Minutes of Regular Quarterly Board Meeting

July 26, 2016
9:30 a.m.

Sawyer State Office Building
555 East Washington Avenue
Room 4401
Las Vegas, Nevada 89102
and
Legislative Counsel Bureau
401 South Carson Street
Room 3138
Carson City, Nevada 89701

I. Chair, Margaret McConnell called the meeting to order at 9:34 a.m.

II. Executive Director, Sandy Lampert called the roll and a quorum was present.

Board Members:

Margaret McConnell, Chair	Mary Ellen Wilkinson, Vice Chair, Excused
Terry Clodt, Sec/Treas.	Lindsay Hansen, M.D.
Jane Gruner, ADSD	Linda Gelinger - Excused
Lilia Sioson	

Staff:

Sophia Long, Deputy Attorney General	Sandy Lampert, Executive Director

Guests:

Jennifer Williams-Woods, ADSD	Michael Fox

III. PUBLIC COMMENTS –

IV. PUBLIC HEARING FOR THE AMENDMENT AND ADOPTION OF REGULATION OF THE STATE OF NEVADA "for possible action"

Chair, Margaret McConnell, called the hearing to order at 9:45 am. The Board was directed to the copy of the amendments as prepared by LCB File R030-16. After hearing no discussion the chair called for a motion. Jane Gruner moved to adopt the amendments. Lindsay Hansen seconded. Motion carried. Hearing was adjourned at 9:50 am.

V. APPROVAL OF THE FOLLOWING PROPOSED DISCIPLINARY ACTION** (Board may go into closed session) "for possible action"

a. Joan MacLennon – Bridge at Paradise Valley – Case No. B-36123
b. Susan Sowers – Red Rock Residential – Case No. B-36133
c. Gerald Hamilton – Bee Hives Homes of Mesquite – Case No. B-36135
d. Marianita Gee – Better Living Care Home – Case No. B-36136
e. Marilou Reyes – Little Angel Care Home – Case No. B-36137
f. Sandy Hicks – The Homestead – Case No. B-36138
g. Sandy Hicks – The Homestead – Case No. B-36139
h. Villahermosa, Lalaine – Las Vegas Alzheimer & Memory Care I – B-36140
i. Aquino, Luz – Angels House Adult Care – Case No. B-36141

Chair, Margaret McConnell, informed the Board that we have received signed settlement agreements for all of the above cases and called for discussion. Sophia Long stated that Item "a" of the agreements had been updated and legal fees in the amount of approximately $730.00 have been added. After hearing no additional comments, the Chair called for a motion. Jane Gruner moved to approve all of the above actions. Lindsay Hansen seconded. Terry Clodt abstained. Motion carried.

VI. SECRETARY'S REPORT:

a. Approve Minutes of April 26, 2016 Meeting "for possible action".

Terry Clodt asked if there were any changes needed to the Minutes. Hearing none, Terry Clodt moved to approve the minutes. Motion carried.

VII. ADMINISTRATIVE REPORT - Executive Director, Sandy Lampert, reported that to date all but approximately 15 files of active administrators have been scanned into the system.

VIII. ADMINISTRATOR LICENSES ISSUED MUST RECEIVE FINAL BOARD APPROVAL WHEN ALL REQUIREMENTS HAVE BEEN MET.

a. Nursing Facility Administrator Licenses Issued "for possible action".
(1) Jensen, Dane M.
(2) Golightly, Shannon

b. Residential Facility Administrator Licenses Issued "for possible action".
(1) Vest, Wade W.
(2) Santos, Allie C.
(3) Cox, James A.
(4) Jensen, Kimberley C.
(5) Uhlir, Cameron M.

c. Inactive Requests "for possible action".
(1) Brown, Stacy - NFA
(2) Hubbard, Lynette - RFA
(3) Cartino, June - RFA
(4) Serrano, Imelda – RFA
(5) Wilding, Geraldine – RFA

Chair, Margaret McConnell asked if there was any discussion regarding Items a, b or c. Hearing none, she called for a motion. Terry Clodt moved to approve. Jane Gruner seconded. Motion carried.

d. Administrator License Renewal ** (Board may go into Closed Session) "for possible action"

(1) Fox, Michael – Chair, Margaret McConnell, directed the Board to the information supplied by Mr. Fox and informed Mr. Fox that he can elect to have the Board go into Closed Session. Mr. Fox chose to go into Closed Session. Session reopened. After some discussion, Jane Gruner moved to approve the renewal of Mr. Fox's license. Lilia Sioson seconded. Motion carried.

IX. UNFINISHED BUSINESS:

a. RCAL AIT Program Reports "for possible action" – Executive Director, Sandy Lampert informed the Board that since the last meeting we have received 9 new applications. We have issued 5 new licenses and currently there are 31 candidates working through the program. 8 are working on the 60 hour Introductory Course, 9 are working on the Nevada Best Practices Training, 4 are doing their AIT and 10 have to pass the NAB Exam. Chair, Margaret McConnell noted that we recently held a Mentor Training in the North, followed by a luncheon to acknowledge current mentors.

b. NFA Report "for possible action" – Chair, Margaret McConnell reported that NAB has developed a Preceptor Training program by a professor at the University of Eau Claire in Wisconsin. The program is very proactive and will be available on line at no cost to State Boards. NAB is also developing an AIT Program. Our Board sent the program to several licensed administrators for their critique. So far, the comments have been very favorable. Chair, Margaret McConnell also reported that she and Executive Director, Sandy Lampert, met with a State Legislator to sponsor a bill to create the new Health Services credential. This license will be purely voluntary, and will allow administrators to provide continuum of care.

X. NEW BUSINESS:

a. Financial Reporting Election "for possible action" – Executive Director, Sandy Lampert, informed the Board that we recently learned that we could elect to have audits every other year instead of annually which would save the Board about $2,000.00 a year. Chair, Margaret McConnell called for a motion. Terry Clodt moved to elect the Biennial Audit. Jane Gruner seconded. Motion carried.

XI. DEPUTY ATTORNEY GENERAL'S REPORT – Sophia Long spoke to the Board about a Continuing Education Seminar presented by FARB for Attorney Generals focusing on Protecting Boards and the public. She asked if the Board would be will to sponsor her attendance. After some discussion, the Board indicated its support and will include reimbursement of expensed on the agenda for the next Board Meeting.

XII. BOARD MEMBER COMMENTS – Chair, Margaret McConnell, on behalf of the Board acknowledged the retirement of Jane Gruner and thanked her for her many years of service.

XIII. PUBLIC COMMENTS

XIV. TIME/DATE/LOCATION OF NEXT REGULAR QUARTERLY MEETING(S) "for possible action" The Board Meeting will be scheduled for Tuesday, October 25, 2016 at 9:30 am.

XV. ADJOURNMENT – The meeting was adjourned at 10:30 am.

Respectfully submitted:

Sandy Lampert

Sandy Lampert
Executive Director

Attested by:

Terry Clodt

Terry Clodt
Secretary/Treasurer

4

B.E.L.T.C.A.

From: Sophia G. Long [SLong@ag.nv.gov]
Sent: Tuesday, October 18, 2016 9:33 AM
To: B.E.L.T.C.A.
Subject: FW: Order Confirmation

From: farb@farb.org [mailto:farb@farb.org]
Sent: Tuesday, September 27, 2016 9:43 AM
To: Sophia G. Long
Subject: Order Confirmation

FARB

Order Date	9/27/2016
Order Total	800.00
Payment Method	AMEX **********
Name on Card	Sophia Long
Ship To	Sophia Long 555 E Washington Ave Ste 3900 Las Vegas, NV 89101-1068

Qty	Item	Price	Total
1	Invoice 1714: 2016 FARB Regulatory Law Seminar - Sophia Long	800.00	800.00

Item Total	0.00
Invoice Total	800.00
Transaction Grand Total	800.00

If you selected "Pay Later" please send a check to FARB or pay by credit card. FARB's FEIN: 23-7375992. Federation of Associations of Regulatory Boards,1466 Techny Road, Northbrook, IL 60062.