DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**11/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS HOME	**4300 DEL MONTE AVE, LAS VEGAS, NEVADA ,89102**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and complaint survey completed at your facility on 11/13/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was 9. Nine resident files and four employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated: Complaint #NV00072189 was substantiated. (See TAG Y0050 and TAG 0853). Investigation of the complaint included: Observations of staff attending to, and checking on residents. Interviews were conducted with a Manager, a Caregiver, a Registered Nurse and residents. Clinical record review of ten residents, including the resident of concern. Document review of facility polices and procedures and incident reports. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0050 SS= G	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS.	0050	Tag #0050 - Administrator's Responsibilities - Oversight A) In-service dated 11/14/2024 to all caregiver's that Hospice residents that is Full Code will initiate CPR to non-responsive residents and call 911. A FULL CODE sign will be put on the room door to alert staff that resident is Full Code. The facility policy is reinforced to all staff what to do when a resident found not breathing/unresponsive. On 11/14/2024 an	11/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EDWIN CB VALENTIN Title: Administrator Date: 12/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Inspector Comments: Based on interview and record review the Administrator failed to ensure caregivers were aware a resident was a full code (to provide full support which includes cardiopulmonary resuscitation (CPR), if the patient has no heartbeat and was not breathing) and was not under a Do Not Resuscitate (DNR) order for 1 of 10 residents (Resident #10). Finding include: Resident #10 (R10) was admitted on 02/02/23 with dementia, and passed away on 09/09/24. On 11/13/24 in the morning, the Manager was interviewed and indicated R10 was found not breathing and unresponsive on 09/09/24 by the Caregiver. R10 was considered a full code at the time of the incident. The Caregiver called the hospice nurse and did not initiate CPR or call 911. The Manager further reported R10 had been declining and was expected to pass away. The facility had tried to get the family to do a Do Not Resuscitate (DNR) order but was unable to get the order prior to this event. The Hospice nurse arrived about 15 minutes after the Caregiver called and the Hospice nurse called 911 and the ambulance came around 10 minutes later. The Manager confirmed R10 was a full code according to the hospice care plans dated 3/01/23 and 09/09/24, but the Caregiver was not notified of this. The facility failed to complete an incident report for this incident. On 11/13/24 at 11:15 AM, a Hospice Nurse/Administrator indicated the facility called them on 09/09/24 after R10 was found unresponsive and not breathing. The Hospice Nurse explained after arriving at the facility, they found 911 had not been called and CPR had not been initiated by facility staff. The hospice nurse called 911, who arrived 15 minutes later. The Hospice Nurse confirmed R10 was a full code and should have received lifesaving interventions such as CPR and 911 should have been called by the facility upon finding R10 unresponsive. R10 was unresponsive and not breathing when 911 arrived. On		incident report was completed by caregiver #4. * Please see attached documents. B) The facility Administrator will In-service caregivers every 3 months to Full Code Hospice residents. A Full Code sign will be obtained from Hospice Agency and will be put on the patients room door to alert staff that resident is Full Code. CPR will be initiated and call 911. The Administrator will monitor for compliant. C) 11/14/2024	

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	11/13/24 at 1:55 PM, the Caregiver indicated they found R10 unresponsive and not breathing on 09/09/24. They reported they did not initiate CPR and did not call 911, instead they called the Hospice Nurse. The Caregiver explained they assumed R10 had a Do Not Resuscitate (DNR) order since R10 was on hospice. The Caregiver confirmed it took about 30 minutes for emergency services to arrive after finding R10 unresponsive. The facility lacked documented evidence of an incident report for R10 being found unresponsive. R10's Hospice Care plan initial summaries dated 03/01/23 and 09/09/24 documented respiratory distress protocol was to give PRN (as needed) oxygen, up to 5 liters. Facility was to call hospice for further direction. CPR was the preference and to attempt CPR since R10 was full code. R10's current Physician Order for Life Sustaining Treatment (POLST) dated 9/3/24 documented to attempt CPR and provide comfort-focused care when not in cardiopulmonary arrest. The facility lacked a policy indicating what to do in the event a resident was found not breathing or unresponsive. On 12/4/24 in the morning, the Manager explained they reviewed all care plans upon receiving them from the hospice company and would hold a meeting with the Caregiving staff to discuss what was in the plan. The Manager revealed they did not notify the Caregivers R10 was a full code. The facility did not have a written policy on the process that was their protocol. They followed the protocol with R10 but didn't recall R10 being a full code. Usually full code residents would be told to the facility by hospice or the health agency and they would also give the facility a sign to put on the room door alerting staff the resident was a full code. Severity: 3 Scope: 1 Complaint #NV00072189			
0850 SS= G	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical	0850	Medical Care of Resident After Illness. A) In-service to all staff regarding Hospice resident who is on full code has been	11/14/2024

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	care by resident; written records. (NRS 449.0302) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on interview, record review and document review, the facility failed to ensure cardiopulmonary resuscitation (CPR) and medical emergency services were called after a resident was found unresponsive for 1 of 10 residents (Resident #10). Findings include: Resident #10 (R10) was admitted on 02/02/23 with dementia and passed away on 09/09/24. On 11/13/24 in the morning, the Manager was interviewed and indicated R10 was found not breathing and unresponsive on 09/09/24 by the Caregiver. R10 was considered a full code at the time of the incident. The Caregiver called the hospice nurse and did not initiate CPR or call 911. The Manager further reported R10 had been declining and was expected to pass away. The facility tried to get the family to do a Do Not Resuscitate (DNR) order but was unable to get the order prior to this event. The Hospice nurse arrived about 15 minutes after the caregiver called and the Hospice nurse called 911 and the ambulance came around 10 minutes later. The Manager confirmed R10 was a full code according to the hospice care plans dated 3/01/23 and 09/09/24, but the care giver was not notified. On 11/13/24 at 11:15 AM, a Hospice Nurse/Administrator indicated the facility called them on 09/09/24 after R10 was found unresponsive and not breathing. The Hospice Nurse reported to telling the facility to call EMS services and they were on their way. The Hospice Nurse explained		completed, that includes initiating CPR and call 911 in the event that a resident is found unresponsive. * Please see attached document. B) A full code sign will be put at the residents door to all Hospice resident that is full code. A full code sign will be obtain from Hospice Agency upon admission. An in-service to all employees will be conducted every 3 months for compliant. The Administrator will monitor for compliant. C) 11/14/2024	

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	after arriving at the facility, they found 911 had not been called and CPR had not been initiated by facility staff. After arriving to the facility, the hospice nurse called 911, who arrived 15 minutes later. The Hospice Nurse confirmed R10 was a full code and should have received lifesaving interventions such as CPR and 911 should have been called by the facility upon finding R10 unresponsive. The Hospice agency does not have specific hospice protocols that document all hospice residents were DNR, The hospice care plans and POLST form both indicated R10 were a full code. R10 was found non-breathing with no heart beat by EMS upon arrival. On 11/13/24 at 1:55 PM, a Caregiver indicated they found R10 unresponsive and not breathing on 09/09/24. They reported they did not initiate CPR and did not call 911, instead they called the Hospice Nurse. The Caregiver explained they assumed R10 had a Do Not Resuscitate (DNR) order since R10 was on hospice. The Caregiver confirmed it took about 30 minutes for emergency services to arrive after finding R10 unresponsive. R10's Hospice Care plan initial summaries dated 03/01/23 and 09/09/24 documented respiratory distress protocol was to give PRN (as needed) oxygen, up to 5 liters. Facility was to call hospice for further direction. CPR was the preference and to attempt CPR further documenting R10 was full code. R10's current Physician Order for Life Sustaining Treatment (POLST) dated 9/3/24 documented to attempt CPR and provide comfort-focused care when not in cardiopulmonary arrest. The facility lacked a policy indicating what to do in the event a resident was found not breathing or unresponsive. On 12/4/24 in the morning, the Manager explained they reviewed all care plans upon receiving them from the hospice company and would hold a meeting with the Caregiving staff to discuss what was in the plan. The Manager revealed they did not notify the Caregivers R10 was a full code. The facility did not have a written			

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	policy on the process that was their protocol. They followed the protocol with the R10 but didn't recall R10 being a full code. Usually full code residents would be told to the facility by hospice or the health agency and they would also give the facility a sign to put on the room door alerting staff the resident was a full code. Severity: 3 Scope: 1 Complaint #NV00072189			
0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on interview and record review the facility failed to ensure an incident report was completed after a resident was found unresponsive. (Resident #10). Findings include: Resident #10 (R10) was admitted on 02/02/23 with dementia and passed away on 09/09/24. R10' s' file and the facility's incident reports lacked documented evidence an incident report was completed when R10 was found unresponsive. On 11/13/24 in the morning, the Manager indicated R10 was found not breathing and unresponsive on 09/09/24 by the Caregiver. R10 was considered a full code at the time of the incident. The Caregiver called the hospice nurse and did	0853	Medical Care of Resident After Illness. A) An incident report has been completed on 11/14/2024. * Please see attached document. B) Whenever a Hospice Resident that is on Full Code that is found unresponsive/unusual event, an incident report will be completed and will be kept in resident file. The Administrator will in-service every 3 months. The Administrator will monitor for compliant. C) 11/14/2024	11/14/2024

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	not initiate CPR or call 911. The Manager further reported R10 had been declining and was expected to pass away. The facility had tried to get the family to get a Do Not Resuscitate (DNR) order but was unable to get the order prior to this event. The Hospice nurse arrived about 15 minutes after the caregiver called and the Hospice nurse called 911 and the ambulance came around 10 minutes later. R10 was found non-breathing and with no heart beat by EMS upon arrival. The Manger verbalized an incident report was not completed after R10 was found unresponsive and should have been. Severity: 2 Scope: 1			

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a medication review was completed every six months and was signed off, by the Administrator, for 1 of 9 residents (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 09/11/21 with diagnosis including Alzheimer's disease. R5's medication review dated 08/29/24 was not signed off by the Administrator and there was no medication review available six months prior to this date. On 11/13/24 in the morning, a Manager confirmed the Administrator had not signed off on R5's six month medication review, and there was no medication review available prior to 08/29/24. Severity: 2 Scope: 1	0870	Medication Administration-Accuracy & Report. A) A medication review for resident #5 has been noted and signed off by the Administrator. * Please see attached document. B) Whenever a resident is admitted to the facility, a medication review will be completed by an RN, Pharmacist and/or Primary physician. A medication review will be completed every 6 months, noted and signed by the administrator. The Administrator will monitor for compliant. C) 12/04/2024	12/04/2024