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 _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKEY ASSISTED LIVING	**3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated in your facility on 08/21/24 and completed on 09/19/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 112 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and assisted living services, Category II residents. The census at the time of the survey was 63. Five resident files and five employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated: Complaint #NV00071521 was substantiated (See TAGS Y850 and Y878). The investigation of the complaint included: Observations included a tour of the facility, no fall hazards in the facility, residents receiving care and assistance, interactions between staff and residents. Interviews were conducted with the Resident of Concern's responsible party, residents, a Housekeeper, a Caregiver, a Medical Technician, a hospice nurse, an Executive Director of a hospice provider, the Memory Care Director, and the Administrator. Record Review of 5 records, which included the resident of concern. Document Review included facility policy and procedures. 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 investigations, 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		
0850 SS= J	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	1) We have corrected the specific findings by training our Shift Supervisors & Medication Technicians in seeing that the new protocols we have established for	09/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRISTOPHER LANE Title: Administrator Date: 10/14/2024

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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 the responsible party and hospice agency of a resident were immediately notified after a resident had a significant change of condition and failed to obtain emergency services for a reported broken leg for 1 of 5 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/18/22 with a diagnosis of coronary artery disease. A Facility Incident Report dated 05/24/24 at 9:58 PM documented R1 was confused, couldn't explain what happened and was found on the floor. R1 complained of left shoulder pain and the facility called 911 and emergency responders transported R1 to a local hospital. On 05/25/24 at 4:06 AM, the facility documented in the 05/24/24 Facility Incident Report that R1's responsible party was notified via telephone which was six hours after the incident occurred. The facility documented contacting R1's responsible party a second time at 7:30 AM which was more than 10 hours after R1 fell at the facility. R1's file lacked documented evidence R1's responsible party was notified of R1's fall prior to the 4:06 AM note. A Facility Incident Report dated 06/07/24 at 7:00 PM documented R1 complained about pain in their leg and accused the Caregivers of trying to break their leg. Caregivers reported trying to transfer R1 from the couch to the wheelchair when R1 complained of pain.		electronic Incident Reports are followed. These electronic reports include a prompt to contact a responsible party/ family member, and the medical provider as soon as possible after an incident or accident happens that involves a resident. 2) We will make the following changes effective September 1, 2024, for all incident reports to be in the new format. This will allow not only clear and concise reading of an incident but seeing the prompts for medical personnel and family members who need to be contacted. 3) We will monitor the corrective action by the electronic program giving the Administrator access to Incident Report entries 24/7 so that he can review them and correct any errors or make follow-up calls that were not able to be completed at time of incident, before he files them on the Incident reports folder. 4) The Administrator will be responsible for ensuring the POC is implemented. 5) 09/01/24 6) (attached Electronic Incident Report sample & ECP on-line Staff Training outline)	

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	The Facility Incident Report dated 06/07/24 and R1's file did not document that the facility notified the R1's responsible party about the incident. Hospice Visit Report dated 06/07/24 documented the facility called the hospice office and reported staff were transferring R1 and R1 stated the caregivers broke R1's leg. A Caregiver explained that two Caregivers were transferring R1 from couch to wheelchair and when R1 got into the wheelchair, R1 stated the caregivers broke their leg. The report documented the Licensed Vocational Nurse (LVN) performed Passive Range Of Motion (PROM) on R1's leg and R1 reported some pain in the entire leg, however R1 did not cry out or yell. The LVN spoke to the Medication Technician (Med Tech) at the facility and told them to give R1 their as needed pain medication. The LVN documented informing the Med Tech that if the pain got worse, hospice could get an order for an x-ray from the hospice doctor, but the facility would have to go through their x-ray company. Facility Care History dated 06/11/24 at 8:00 AM documented R1 was not mobilizing due to pain in their right leg and left arm. Facility Care History dated 06/11/24 at 9:00 AM documented R1 was given a bed bath due to being in pain. Facility Care History dated 06/11/24 at 11:00 AM documented the facility checked on R1 as R1 was in pain. Facility Care History dated 06/11/24 at 12:01 PM documented R1 was not mobilizing due to pain in their leg and arm. R1's file lacked documented evidence of the hospice agency being notified of R1 being in pain and not mobilizing. A Facility Incident Report dated 06/11/24 at 12:04 PM documented R1 wanted to go to the hospital. The facility contacted hospice and spoke to the nurse who reported they had just been at the facility and did a range of motion on the R1's leg. Hospice instructed the Medication Technician to give R1 pain reliever and Lorazepam. Hospice said not to send R1 to the hospital. The facility			

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	contacted R1's responsible party at 12:21 PM and R1's responsible party said not to send R1 to the hospital. Facility Care History dated 06/12/24 at 6:00 AM documented R1 seemed to be in less pain due to medication administration. Right leg was still swollen and bruised, left arm was sensitive to touch and a Medication Technician was notified. Facility Care History dated 06/12/24 at 6:19 AM documented R1 was not mobilizing due to pain. Facility Care History dated 06/12/24 at 7:18 AM documented R1 was not mobilizing due to pain in leg and arm. Facility Care History dated 06/13/24 at 6:00 AM documented R1 was in bed, still had pain in their leg and arm. Facility Care History dated 06/13/24 at 8:37 AM documented R1 was in bed and not mobilizing due to pain. Facility Care History dated 06/13/24 at 8:40 AM documented R1 was not mobilizing due to pain in their leg and arm. Facility Care History dated 06/13/24 at 12:33 PM documented R1 was not mobilizing due to pain in their leg and arm. Facility Care History dated 06/13/24 at 12:34 PM documented R1 was not mobilizing, lying in bed due to pain in their leg and arm. The 06/13/24 Hospice Visit Report, documented that facility staff reported R1 had been refusing to eat and was sleeping 18 - 20 hours a day. Staff reported R1 moans with changes and refuses to be repositioned and stated R1 was Hard of hearing (HOH) and difficult to communicate with. Hospice documented R1 appeared comfortable and that the right upper leg continued with bruising. Facility Care History dated 06/14/24 at 6:00 AM documented R1 was in discomfort, had pain in their right leg, pain in their left hand. Med Tech and social worker were informed. Facility Care History dated 06/14/24 at 12:00 PM documented R1 was not mobilizing due to pain in their right leg and arm. A Facility Physician's Communication Form dated 06/16/24 documented R1 was unable to swallow the medication and was refusing the			

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	medication. Facility Care History dated 06/17/24 at 10:09 AM documented R1 was not mobilizing due to pain in their right leg and arm. Hospice Visit Report dated 06/17/24 documented the Hospice Nurse reported R1 had swelling and limited range of motion of right thigh and leg. Facility Caregiver reported R1 had not been able to swallow medications for 5 days. Physician's Order was sent to discontinue all medications and start liquid comfort medications. Bruising was noted on both lower extremities and an X-ray was ordered. Radiology Report dated 06/17/24 at 10:15 PM documented a possible right mid femoral fracture. Recommended femur radiographs. Facility Care History dated 06/18/24 at 6:00 AM documented R1 was not able to move around due to right leg and left arm in pain. Facility Care History dated 06/18/24 at 12:02 PM documented R1 was bedbound due to a swollen leg and arm pain. R1 passed away on 06/19/24 in the facility. On 08/22/24 in the morning, E2 who was a Medical Technician verbalized the facility process for when a resident fell was to contact the resident's family immediately after calling 911 or hospice. The process for a resident in pain was to first ask the resident if they needed medical assistance, then give pain medication if needed, and communicate with the resident's physician. On 08/22/24 in the morning, E3 who was a Caregiver reported the facility policy for when a resident fell was to always take care of the resident first, assess the resident, call the resident's doctor or 911 and then contact the resident's family. If they came across a resident who appeared to be in pain, they would first observe them, call a Medication Technician, call a supervisor, and contact their physician about their discomfort and contact their family. On 08/22/24 in the afternoon, the Administrator acknowledged that on 05/25/24 the facility contacted R1's responsible party after 4:00 AM and verbalized not being sure why they waited			

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	so long to contact the responsible party. Regarding the incident on the evening of 06/07/24, the Administrator indicated they were unaware if R1's responsible party was notified after the incident occurred. The Administrator verbalized that staff were to contact residents' responsible parties as soon as possible following an incident and the facility should have contacted R1's responsible party sooner on 05/25/24. On 08/27/24 in the morning, the Memory Care Director acknowledged that R1 had fallen on 05/24/24 at approximately 10:00 PM and confirmed R1's responsible party was not notified by the facility until approximately 4:00 AM on 05/25/24. The Memory Care Director verbalized the facility should contact the resident's responsible party immediately after calling 911 and R1's hospice provider. The Memory Care Director verbalized the facility should have reached out to the hospice provider every time R1 was in pain. The Memory Care Director acknowledged the facility should have sent R1 to the hospital and not relied on hospice. On 09/11/24 in the afternoon, R1's responsible party verbalized they were contacted by the facility shortly after 4:00 AM on 05/25/24 regarding the incident on 05/24/24 where R1 sustained a left shoulder fracture. R1's responsible party reported the facility did not contact them regarding the 06/07/24 incident where R1's leg was reported broken. R1's responsible party verbalized learning of the incident from the hospice agency on 06/07/24. R1's responsible party reported the hospice agency notified them of R1's broken femur bone on 06/17/24. Facility Incident Policy (undated) documented (5) it was very important to contact the Family Member, Power of Attorney, Guardian of whomever was the responsible party for the resident. The facility needs to know that staff called the person, the full name and title of the person called and relation to the resident. It was also important to let them know what happened and if transported to the hospital,			

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	which hospital. If there was no answer, leave a message then try and text. Attempt two more call backs within the next 15 minutes in case they were not near their phone. If no direct contact, make a note in the comment section so the Administrator can follow up later. An email dated 09/12/24 at 11:45 AM from the Administrator reported the delay in reporting was an isolated incident. Severity: 4 Scope: 1 Complaint # NV00071521			
0878 SS= J	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change	0878	1) We will correct the specific findings by having the medication technician's refresh their training on the Medication Plan currently in place. Our plan was to order at least 7 days in advance of the last dose, with a follow-up in 4 days if the meds have not arrived. We will also not make verbal communications with a PCP, Hospice or Home Health Nurse, without a follow-up documented (written) communication form completed as well. This documented communication will now go in the resident's folder after verification of delivery. 2) We will make the following additional training so that Medications will never run out of Meds due to failure on our part of not correctly ordering medications or not documenting verbal communications to a resident's PCP regarding re-ordering meds. 3) We will monitor the corrective action by having our bi-monthly Medication Audits increased to weekly audits until management is convinced their Medication Plan training has been understood and followed, and medical communications are documented properly. 4) The Director of Care Services will be responsible for ensuring the POC is implemented. 5) 09/01/24 6) (See attached page 4 of Med Plan [Ordering in highlights], and copy of a blank Medical Communication form)	08/23/2024

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	has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to ensure pain medications were onsite, to contact the physician of a resident's refusal of pain medications in a timely manner and medications were given as prescribed for 1 of 5 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/18/22 with a diagnosis of coronary artery disease. Hospice Visit Note dated 05/25/24 documented R1 experienced a fall the previous night on 05/24/24 and was found to have sustained a left shoulder fracture. R1 was released from the emergency room with their arm in a sling. A Facility Incident Report dated 06/07/24 at 7:00 PM documented R1 complained about pain in their leg and accused the Caregivers of trying to break their leg. Caregivers reported trying to transfer R1 from their couch to their wheelchair when R1 complained of pain. Radiology Report dated 06/17/24 at 10:15 PM documented a possible right mid femoral fracture. Recommended femur radiographs. R1's physician's order dated 05/29/24 documented Hydrocodone 7.5			

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	milligrams (mg) - Acetaminophen 325 mg tablet, take 1 tablet every 4 hours for pain. R1's Medication Administration Record (MAR) for June 2024 documented Hydrocodone-Acetaminophen 7.5 - 325 milligrams, take 1 tablet by mouth every 4 hours for pain. The June 2024 MAR on 06/09/24 at 12:07 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to waiting for orders from R1's physician. The June 2024 MAR on 06/09/24 at 5:20 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to waiting for the delivery of the medication. The June 2024 MAR on 06/09/24 at 7:04 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to waiting for the delivery of the medication. The June 2024 MAR on 06/09/24 at 10:55 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to waiting for orders. The June 2024 MAR on 06/10/24 at 4:25 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain. The June 2024 MAR on 06/10/24 at 8:23 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to waiting for the delivery of the medication. The June 2024 MAR on 06/11/24 at 2:01 AM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to R1 awaiting a refill. Facility Care History dated 06/11/24 at 8:00 AM documented R1 was not mobilizing due to pain in their right leg and left arm. Facility Care History dated 06/11/24 at 9:00 AM documented R1 was given a bed bath due to being in pain. Facility Care History dated 06/11/24 at 11:00 AM documented the facility checked on R1 as R1 was in pain. Facility Care History dated 06/11/24 at 12:01 PM documented R1 was not mobilizing due to			

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	pain in their leg and arm. The facility received Hydrocodone 7.5 mg in the afternoon of 06/11/24. Facility Care History dated 06/12/24 at 6:00 AM documented R1 seemed to be in less pain due to medication. Right leg was still swollen and bruised, left arm was sensitive to touch and a Medication Technician was notified. Facility Care History dated 06/12/24 at 6:19 AM documented R1 was not mobilizing due to pain. Facility Care History dated 06/12/24 at 7:18 AM documented R1 was not mobilizing due to pain in leg and arm. The June 2024 MAR on 06/12/24 at 8:21 AM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to pain. On 08/21/24 staff could not explain the entry on 06/12/24 at 8:21 AM which documented R1 did not receive pain medication due to pain. The June 2024 MAR on 06/13/24 at 6:08 AM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to R1 refusing the medication. Facility Care History dated 06/13/24 at 6:00 AM documented R1 was in bed, still had pain in their leg and arm. Facility Care History dated 06/13/24 at 8:37 AM documented R1 was in bed and not mobilizing due to pain. Facility Care History dated 06/13/24 at 8:40 AM documented R1 was not mobilizing due to pain in their leg and arm. Facility Care History dated 06/13/24 at 12:33 PM documented R1 was not mobilizing due to pain in their leg and arm. Facility Care History dated 06/13/24 at 12:34 PM documented R1 was not mobilizing, lying in bed due to pain in their leg and arm. The 06/13/24 Hospice Visit Report, documented that facility staff reported R1 had been refusing to eat and was sleeping 18 - 20 hours a day. Staff reported R1 moans with changes and refuses to be repositioned and stated R1 was Hard of hearing (HOH) and difficult to communicate with. Hospice documented R1 appeared comfortable and that the right upper leg continued with bruising. Facility			

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	Care History dated 06/14/24 at 6:00 AM documented R1 was in discomfort, had pain in their right leg, pain in their left hand. Med Tech and social worker were informed. Facility Care History dated 06/14/24 at 12:00 PM documented R1 was not mobilizing due to pain in their right leg and arm. The June 2024 MAR on 06/15/24 at 8:20 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to R1 refusing the medication. The June 2024 MAR on 06/15/24 at 11:37 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to R1 refusing the medication. The June 2024 MAR on 06/16/24 at 9:05 AM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to R1 refusing the medication. The June 2024 MAR on 06/16/24 at 2:05 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain due to R1 refusing the medication. The June 2024 MAR on 06/16/24 at 4:11 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain. The reason documented for the missed dosage of medication was other. The June 2024 MAR on 06/16/24 at 7:37 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain. The reason documented for the missed dosage of medication was other. The June 2024 MAR on 06/16/24 at 11:59 PM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain. The reason documented for the missed dosage of medication was other. A Facility Physician's Communication Form dated 06/16/24 documented R1 was unable to swallow the medication and was refusing the medication. The June 2024 MAR on 06/17/24 at 5:56 AM documented R1 did not receive Hydrocodone-Acetaminophen 325 milligrams (mg) for pain. The reason documented for the missed dosage of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	medication was other. The 06/17/24 Hospice Visit Report - documented the Hospice Nurse reported R1 had swelling and limited range of motion of right thigh and leg. Bruising was noted on both lower extremities. Facility Caregiver reported R1 was not able to swallow medications for 5 days and Caregiver reported being concerned about fracture of right thigh due to the fall the resident had a few weeks ago. Physician's order was sent to Discontinue all medications and start liquid comfort medications and an Xray was ordered. On 09/11/24 in the afternoon, R1's responsible party reported the hospice agency notified them of R1's broken femur bone on 06/17/24. R1 passed away on 06/19/24 at the facility. R1's file lacked documented evidence the hospice agency or the physician was notified of Hydrocodone 7.5 mg not being onsite from 06/09/24 through 06/11/24, R1 being in pain from 06/11/24 through 06/14/24 and R1 refusing the pain medication from 06/13/24 through 06/15/24. On 09/05/24 in the morning, the Memory Care Director acknowledged R1's pain medication was not onsite on 06/09/24, 06/10/24 and a portion of 06/11/24 and the facility received the pain medication on site in the afternoon on 6/11/24. The Memory Care Director verbalized the facility called hospice about the missed medications from 06/09/24 through 06/11/24. On 09/05/24 in the morning, the Memory Care Director could not provide documentation that the hospice agency was notified of the missed medications. On 09/05/24 in the morning, the Memory Care Director explained a nurse from hospice was on site every day during the time R1 was not being administered pain medication. The Memory Care Director verbalized they told the nurse verbally one of the days R1 was not being administered pain medications. The only documented evidence regarding the hospice nurse being informed R1was not being administered the pain medications and not being able to swallow their			

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

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	medications was the Physician's Communication Form dated 06/16/24 sent to the hospice agency. On 09/19/24 in the afternoon, the hospice nurse verbalized not recalling if the facility had notified hospice regarding R1's medications not being onsite 06/09/24, 06/10/24 and a portion of 06/11/24. The hospice nurse reported not being informed about R1 not being able to swallow their pain medications. Severity: 4 Scope: 1 Complaint # NV00071521			