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 _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ANGEL CARE HOME LLC	**2570 KEYSTONE AVE, RENO, NEVADA ,89503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation State Licensure survey conducted at your facility on 12/12/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for five Residential Facility for Group beds for elderly or disabled persons, and/or chronic illness, and/or intellectual disabilities, and/or mental illness, Category II residents. The census at the time of the survey was five. There was one complaint investigated. Complaint #NV00069663 with an allegation of roaches and bed bugs in the facility could not be substantiated due to lack of evidence. The investigation into the allegation included: Observations of residents in their rooms and common areas. Inspection of all areas of the kitchen, the three resident rooms including the five residents' mattresses and floors, two bathrooms, the living room, the dining room, the laundry area, and the garage. Interviews with two residents and the Caregiver. Record review of physician progress notes, hospice progress notes, physician orders, ultimate user agreements, and resident medications. Document review of pest control contract, medication plan policy, medication destruction and removal policy, infection control plan, and December 2023 staffing schedule. As a result of the investigation, medications were found unsecured in a kitchen cabinet, the facility's infection control plan did not contain all of the required regulatory elements, the facility's infection control plan did not designate a primary and secondary person responsible for infection control, and staff lacked the required infection control training (see Tag Y0920, Y1810, Y1825, and Y1830). The facility received a grade of B. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARILOU A REYES Title: Administrator Date: 01/15/2024

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.

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 _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ANGEL CARE HOME LLC	**2570 KEYSTONE AVE, RENO, NEVADA ,89503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 deficiencies were identified:			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured and safe from being accessed by residents and/or visitors to the facility. Findings include: On 12/12/23 at 9:24 AM, during an inspection of the kitchen environment, the following medications were found in an unsecured lower cabinet in the kitchen: Resident #1 - one container of famotidine 20 milligrams (mg), take one tablet by mouth twice a day. Resident #2 - one bottle of morphine 100 mg/5 milliliters (ml), take 0.25 ml by mouth every hour as needed. - one container of Mi-acid gas relief 80 mg, take one tablet four times a day as needed. - two containers of ibuprofen 400 mg, take one	0920	1. Administrator educate the caregiver/s that all medications(prescriptions/OTC)being discontinued by the provider should be destructed in the proper way (using a kitty litter) 2. Facility will ensure all discontinued medications will be stored in a locked cabinets while waiting for proper destruction 3. Administrator will be checking daily if caregiver/s are following the policy 4. Administrator will be responsible for implementing the correction 5. Jan 3, 2024 6. See attached documentations	01/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ANGEL CARE HOME LLC	**2570 KEYSTONE AVE, RENO, NEVADA ,89503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tablet by mouth twice a day. - one container of spironolactone 25 mg, take one tablet by mouth daily. - two containers of amlodipine besylate 10 mg, take one tablet by mouth daily. - one container of haloperidol 0.5 mg, take one tablet by mouth as needed every four hours for restlessness. - one container of Senna plus 8.6 mg-50 mg, take one tablet by mouth as needed daily for constipation. - one container of Promethazine 25 mg, take one tablet by mouth as needed every four hours for nausea and/or vomiting. - one container of lorazepam 0.5 mg, take one tablet every four hours as needed for restlessness. - one container of famotidine 20 mg, take one tablet by mouth twice a day. Resident #3 - one container of quetiapine fumarate 50 mg, take one tablet by mouth at bedtime. - one container of olanzapine 5 mg, take one tablet by mouth daily at bedtime. Resident #4 - one container of Divalproex 125 mg, take one tablet by mouth twice a day. - one container of potassium chloride 100 mg, take one tablet by mouth daily. - one container of vitamin C 500 mg, take one tablet by mouth daily. - one inhaler of albuterol HFA 90 micrograms (mcg), inhale one puff by mouth every four hours as needed for shortness of breath. - one container of Lisinopril 5 mg, take one tablet by mouth daily. Resident #5 - one container of Hydralazine 25 mg, take one tablet by mouth three times a day. - four bottles of lubricant eye drops 0.5%, instill one drop in both eyes three times a day as needed for dry eyes. On 12/12/23 at 9:30 AM, the Caregiver confirmed the medications were unsecured in the kitchen cabinet and verbalized the medications were discontinued and should be secured until destroyed per the facility's policy. The facility policy titled "Medication Plan Policy," undated, documented medications are stored in a secure area. Severity: 2 Scope: 3			

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 _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ANGEL CARE HOME LLC	**2570 KEYSTONE AVE, RENO, NEVADA ,89503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
1810 SS= F	Infection Control Program Inspector Comments: Based on document review and interview, the facility failed to develop a comprehensive infection control program and corresponding policies to prevent and control infections within the facility with the potential to affect 5 of 5 residents. Findings include: On 12/12/23, the facility lacked a comprehensive infection control program with infection control policies in place to ensure the safety needs of residents, staff, and visitors. The facility's infection control program lacked: - Designation of a person to be responsible for coordinating the infection control program for the facility. - Policies and procedures for the control of infectious diseases that are based on current nationally recognized, evidence-based guidelines for the prevention and control of infectious diseases (such as from CDC). - Policies and procedures that reflect the scope and complexity of the services the facility provides. - A strategy for addressing an outbreak of an infectious disease and the effects of such an outbreak at the facility, including, without limitation, staffing shortages, new admissions and readmissions, visitation and protecting residents, patients or clients from the spread of the infectious disease. On 12/12/23 at 10:55 AM, the Caregiver confirmed the facility had not designated the primary and secondary staff responsible for the facility's infection control in a policy and produced an infection control plan only addressing COVID-19 protocols. The Infection Control Plan lacked documented evidence of current guidelines for infection control specifically for the facility. Severity: 2 Scope: 3	1810	1. Administrator will update the facility's Infection Control Policy if needed 2. Same as number 1- Facility will update Infection Control Policy if needed and follow the same policy with the Covid-19 policy 3. Administrator will checked CDC guidelines for any updated information about infection control 4. Administrator is responsible for ensuring the POC were implemented 5. January 3, 2024 6. See attached document	01/03/2024

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 _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ANGEL CARE HOME LLC	**2570 KEYSTONE AVE, RENO, NEVADA ,89503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
1825 SS= F	I C Program Responsible Person and Designee Inspector Comments: Based on interview and record review, the facility failed to ensure a primary and secondary person responsible for the facility's infection control program were identified with the potential to affect 5 of 5 residents. Findings include: On 12/12/23 at 10:55 AM, the Caregiver verbalized the facility had not designated a primary and secondary person responsible for the facility's infection control program. Severity: 2 Scope: 3	1825	1. Administrator has designated the primary and secondary staff responsible for coordinating the Infection Control program in the facility 2. Primary and secondary staff will be consistently communicate on how to prevent infections in the facility 3. Same as number 2- Primary and secondary staff will continue to communicate about the prevention of infection in the facility 4. Administrator will ensure the POC are being implemented 5. January 3, 2024 6. See attached document	01/03/2024
1830 SS= F	Infection Control Required Training Inspector Comments: Based on personnel file review, document review, and interview, the facility lacked a primary and secondary infection control person with the required infection control training with the potential to affect 5 of 5 residents. Findings include: On 12/12/23 at 10:55 AM, the Caregiver confirmed the required infection control and prevention training had not been completed by any employee working in the facility. Severity: 2 Scope: 3	1830	1. Administrator will make sure that all staffs of the facility will receive proper training for Infection Control per CDC's guidelines 2. Staff will be taking the proper training for Infection Control 3. Administrator will monitor that staffs of the facility were getting their training annually 4. Administrator is the responsible to ensure trainings are being done 5. January 3, 2024 6. See attached documents	01/03/2024