Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2787	A. BUILDING _____ B. WING _____	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS CARE HOME	**5125 MEADOWS LILLY AVE, LAS VEGAS, NEVADA ,89108**

(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 an annual State Licensure survey conducted in your facility on 12/28/17. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness and/or persons with chronic illnes. The census at the time of the survey was six. Six resident files were reviewed and five employee files were reviewed. The findings and conclusions of any investigation by the Health Division 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 facility received a grade of A. The following deficiencies were identified:	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARINA VAUGHN Title: Administrator Date: 01/04/2018

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0923 SS= E	449.2748(3)(a-b) - Medication Container - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to keep medications belonging to 3 of 6 residents in their original container (Resident #3, #4 and #5). Findings include: On 12/28/17 at 11:25 AM, three medication bottles were on the kitchen counter with a hand written label with resident names on it and the word Noon. One container with Resident #3, another with Resident #4 and the third with Resident #5's name on the medication bottle. Each bottle had one pill in it. The medications were prepared 35 minutes prior to the time the resident's should have received the medications. On 12/28/17 at 11:25 AM, Caregiver #2 reported the pills were Resident #3, #4 and #5's 12:00 PM medication (Noon) and was going to give the resident's the medication at Noon. The Caregiver explained the residents hold the medication bottle and tipped the bottle so the pill would have gone into the resident's mouth. The caregiver showed the container the pills originally came from and acknowledged the pills were not in the original container. Severity: 2 Scope: 2	0923	A. Administrator reminded the Caregivers that although medications can be given an hour before and after the specified time, once it is taken out from its original container, it must be immediately given to the intended Resident. B. Administrator, Owner and Caregivers from hereon shall remind, monitor, check and counter check the designated med-aide/tech during medication administration time to ensure that no pre-pouring shall occur again in compliance with NAC 449.2748 (3)(a-b). C.Accomplished 12-28-2017	12/28/2017