STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305	A. BUILDING _____ B. WING _____	04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER'S BEST CARE FOR ELDERLY	1225 S 8TH STREET, LAS VEGAS, NEVADA ,89104

(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 and infection control survey conducted at your facility on 04/26/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for persons with mental illness, Category II residents. The census at the time of survey was ten. Ten resident files and three employee files were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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		
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions	0878	Findings is due to a confusion with an order from the Psychiatrist that was noted on the MAR in Nov 2021. The Caregivers were not notified of the new order just that the MAR shows a conflicting entry where it says 2 times daily but only shows to be given at bedtime. After the survey, Administrator right away called the pharmacy to find out what the actual order is. The order is dated 02/08/2022 for Depakote ER 500 mg Oral Tablet Extended BID (copy of order attached). This error is right away corrected. To prevent errors like this from	04/26/2022

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	of the physician. 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 must be administered as prescribed by the physician. If a physician 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 has occurred; and (Previously Y 0879) (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 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, the 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 record review and interview, the facility failed to ensure medication was administered as prescribed for 1 of 10 residents (Resident #2). Findings include: Resident #2 (R2) was admitted on 04/26/19 with diagnoses including acute kidney failure, anemia, hypothyroidism, and heart failure. A physician's order dated 03/29/22 prescribed Divalproex Sodium E 500 milligram (mg) tablet ER, take one tablet by mouth twice daily. The MAR listed this medication was administered once daily. On 04/26/22 at 1:30 pm, the Administrator confirmed R2's medication was not being administered in accordance with the physician's order. Severity: 2 Scope: 1		re-occurring, Administrator will continue to monitor MAR by doing monthly audits. (copy of MAR attached)	

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0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR) accurately documented the medications for 2 of 10 residents (Residents #2 and #5). Findings include: Resident #2 (R2) was admitted on 04/26/19 with diagnoses including acute kidney failure, anemia, hypothyroidism, and heart failure. A physician's order dated 03/29/22 prescribed Divalproex Sodium E 500 milligram (mg) tablet ER, take one tablet by mouth twice daily. The MAR listed this medication to be taken once daily. Resident #5 (R5) was admitted on 05/17/19 with diagnoses including dementia, hypertension, and hypothyroidism. On 04/07/21, R5 was prescribed Trazadone HCL 150 milligram (mg), take one table by mouth at bedtime. On 11/10/21, this medication was discontinued by the physician. The medication was not on-site but was listed in the MAR as being administered once daily at bedtime. On 04/26/22 at 1:30 pm, the Administrator confirmed the MARs for R2 and R5 were inaccurate. The Administrator acknowledged R5's MAR listed a medication as being administered after being discontinued on 11/10/21. Severity: 2 Scope: 1	0895	Findings shows that the MAR for Resident #5 indicates that the med is being given when we don't have the actual med in the facility. Upon further inspection, it was determined that the med Trazodone has been discontinued and the pharmacy failed to remove it from the MAR hence the oversight of signing it. It was noted on previous MAR that it was DC but was not noted on the present MAR. Administrator right called the pharmacy to correct this error. To avoid this error from re-occurring, Administrator will continue to monitor by MAR by monthly audits. (copy of corrected MAR)	04/26/2022