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
	339	A. BUILDING _____ B. WING _____	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME CARE FACILITY	4920 RONAN DRIVE, LAS VEGAS, NEVADA ,89110

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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 05/08/18. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness. Category I residents. The census at the time of the survey was seven. Seven resident files were reviewed and two employee files were reviewed. 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 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		
0178 SS= F	449.209(5) - Health and Sanitation-Maintain Int/Ext - NAC 449.209 Health and sanitation. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the exterior premises were clean and well-maintained. Findings include: On 05/08/18, in the morning, the following was observed: - The entire back patio floor had build-up of dirt and grime. A resident was laying on the bare floor to rest. - In the backyard, there were overgrown weeds on the curb. - In the backyard, a fallen branch with dried leaves was hanging partially from the tree. On 05/08/18, the Administrator acknowledged the findings and explained they didn't have time to cut the fallen branch. The Caregiver indicated the resident loved laying on the ground and did it everyday. Severity: 2 Scope: 3	0178	0178 - Entire back patio was not built up with dirt. (see picture labeled before water). There was dry leaves in the corner caused from wind. A few weeds by the shed were removed while the inspector was on site. There was a hanging branch, not a hazard, caused by wind storm, that was cut/removed the day the inspection when the inspector left. We purchased a saw for the project. The client laying on the patio floor while listening to music has been told not to lay on the floor. This client has a tendency to lay down anywhere during the day. The facility created an environmental weekly check list so this deficiency will not occur in the future.	05/22/2018
0870	449.2742(1)(a-c) 2 - Medication	0870	0870- Resident #1 does not have a	05/22/201

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SS= F	Administration - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers 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; and (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). 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident ' s physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the facility failed to ensure medication review was completed every six months for 5 of 7 residents (Residents #1, #2, #3, #6 and #7). Findings include: Resident #1 Resident #1 was admitted on 07/25/01, with diagnoses including chronic obstructive pulmonary disease, schizoaffective disorder, chronic rhinitis and Vitamin B12 deficiency. The resident's records revealed the last medication review was completed on 05/17/17. The resident's file lacked documented evidence of medication review in November 2017. Resident #2 Resident #2 was admitted on 09/03/96, with diagnoses including schizophrenia, mild obstructive sleep apnea and mild cognitive		medication review for November 2017, however, Resident #1 has a medication review for December 13, 2017. Resident has a current medication review for May 16, 2018. (see attached document) Resident #2 has a medication review for July 31, 2017, March 16, 2018 and a current review for May 7, 2018. (see attached document) Resident #3 has a medication review for May 17, 2017, October 11, 2017, and a current review for May 16, 2018. Resident #6 has a medication review for February 8, 2017, August 09, 2017, and a current review for February21, 2018. (see attached document) Resident #7 has a current medication review for May 5, 2018. (see attached document) Prime Care Facility has created a monthly residence check list that includes residences medication review every 6 months, T.B. test every year, Physical assessment every year. This will be posted in the facility.	8

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	impairment. The resident's records revealed the last medication review was completed on 02/10/17. the resident's file lacked documented evidence of medication review in August 2017 and February 2018. Resident #3 Resident #3 was admitted on 07/05/12, with diagnoses including paranoid schizophrenia, high blood pressure, anemia, hemorrhoids, renal cyst and Vitamin D deficiency. The resident's records revealed the last medication review was completed on 10/02/16. The resident's file lacked documented evidence of medication review in April 2017, October 2017 and April 2018. Resident #6 Resident #6 was admitted on 10/15/14, with diagnoses including chronic obstructive pulmonary disease, chronic schizophrenia, high blood pressure, obstructive sleep apnea, degenerative disc disease and degenerative joint disease. The resident's records revealed the last medication review was completed on 08/15/16. The resident's file lacked documented evidence of medication review in February 2017, August 2017 and February 2018. Resident #7 Resident #7 was admitted on 08/01/08 with diagnoses including chronic schizophrenia, iron deficiency anemia, chronic gastritis and Vitamin D deficiency. the resident's records revealed the last medication review was completed on 04/12/17. The resident's file lacked documented evidence of medication review in October 2017 and April 2018. On 05/08/18, in the afternoon, the Administrator acknowledged the findings and called the physician's office to request copies of the medication review. Severity: 2 Scope: 3			
0878 SS= E	NAC 449.2742(5)(6) - Medication / OTCs, Supplements, Change Order - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers 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 of	0878	0878- Resident #2 - Isosbide 60mg was refilled May 22, 2018. During the inspection Resident #2, medication bottle was not empty. The inspector said the medication would be out on May 28, 2018. However, I was able to get medication on May 22, 2018. (see attached document) The doctors order was sent electronically to pharmacy. (see picture attached) Resident #3 This medication is only prescribed 2x a week, Tuesday and Thursday. The bottle was empty because the refill is done on every Wednesday. The	05/22/2018

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	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 (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 observation, interview and record review, the facility failed to ensure medications were administered as prescribed to 3 of 7 residents (Residents #2, #3, and #4). Findings include: Resident #2 Resident #2 was admitted on 09/03/96, with diagnoses including schizophrenia, mild obstructive sleep apnea and mild cognitive impairment. The Medication Administration Record (MAR) for May 2018 included Isosorbide 60 milligrams (mg), take one tablet by mouth for 90 days. The medication was labeled Isosorbide 60 mg, take one-half tablet by mouth for 90 days. It was dispensed on 03/05/18 with 45 tablets. Pill count revealed there were 19 doses left; the medication will run out on 05/28/18. The next refill will not be until 06/05/18. The resident's file did not include a doctor's order. The Medication		inspector came Tuesday, May 8, 2018, but, sited this as a deficiency. (see attached picture) Ferrous suifate 325 mg. The inspector saw a gap from May 1 to May 7. The reason is the request was done on May 1, 2018. The doctor was not approved by medicate at that time. May 8, 2018 I was able to get the medication (refill). Resident #4 - Proventil 90 mcg Inhaler. The resident has asthma and uses the inhaler 4x a day. The doctor prescribed the inhaler daily use. Sent it electronically to the pharmacy.	

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	List dated 03/16/18 included Isosorbide 60 mg, 0.5 tablet by mouth once a day for 90 days. Resident #3 Resident #3 was admitted on 07/05/12, with diagnoses including Vitamin D deficiency. The MAR for May 2018 listed Vitamin D 1,000 units, take one tablet only every Tuesday and Thursday. The medication was not on site. The MAR for May 2018 included Ferrous Sulfate 325 mg, take one tablet orally every day. The MAR was not initialed as administered from 05/01/18 through 05/07/18. On 05/08/18 at 11:40 AM, the Caregiver acknowledged the resident missed seven doses because the medication was delivered on 05/08/18. The Administrator explained the insurance did not approve Ferrous Sulfate before 05/01/18. Resident #4 Resident #4 was admitted on 11/01/17, with diagnoses including asthma. The MAR for May 2018 included Proventil 90 microgram (mcg), inhale two puffs every four hours. The MAR documented the medication was administered routinely four times a day, every day. The medication was labeled Proventil HFA 90 mcg, inhale two puffs every four hours as needed (may self-administer). The Medication List dated 12/13/17, signed by the resident's physician included ProAir, two puffs every four hours as needed. On 05/08/18 at 11:42 AM, the Administrator explained the resident would ask for Proventil four times a day every day. The was not documentation of "as needed" administration. This was a repeat deficiency from the 06/29/17 annual survey. Severity: 2 Scope: 2			

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0905 SS= D	449.2746(1)(a)-(c) - PRN Medication - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. 1. A caregiver employed by a residential facility shall not assist a resident in the administration of medication that is taken as needed unless: (a) The resident is able to determine his need for the medication. (b) The determination of the resident's need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure the "as needed" medication of 1 of 7 residents included specific instructions for frequency of administration (Resident #1). Findings include: Resident #1 was admitted on 07/25/01, with diagnoses including chronic obstructive pulmonary disease. The Medication Administration Record (MAR) for May 2018 included Proventil HFA 90 micrograms (mcg), inhale two puffs orally every four to six hours. The medication was administered four times a day, but the hours were not specified on the MAR. The medication was labeled Proventil 90 mcg, inhale two puffs orally every four to six hours as needed. It was dispensed on 04/18/18. The medication had a range and required the Caregiver to make an assessment on how often to administer Proventil. The resident's file did not include a doctor's order. The Administrator explained the order was called-in by the doctor to the pharmacy directly. On 05/08/18 at 10:50 AM, the Administrator indicated they administered Proventil every day, four times a day because the resident needed it.	0905	0905- Resident #1 - Proventil HFA 90 mcg Proventil was given daily. The MAR has been changed to specific hours. The doctor has prescribed Proventil 2x a day (daily). (see attached documents)	05/22/2018