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 _____	**03/21/2019**

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

(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 and complaint investigation conducted in your facility on 03/21/19. The State Licensure survey and complaint investigation were conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was 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 six residents. Six resident files were reviewed and three employee files were reviewed. There was one complaint investigated. Complaint #NV00056091 was substantiated. The allegations the facility failed to ensure a resident was provided protective supervision and medications were administered as ordered were substantiated (See Tags Y515 and Y878). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JOSEFINA ADAMS Title: administrator Date: 06/10/2019

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.

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0088 SS= D	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on observation, interview and document review, the facility failed to maintain a staffing schedule which listed the number and types of staff members assigned to each shift. Findings include: On 03/21/19 at 9:00 AM, during a facility tour, one Caregiver was observed in the facility. The Caregiver indicated being the only staff member at the facility. The Caregiver indicated the Administrator would be arriving to the facility later. The Caregiver explained the facility had a staff schedule but was unsure where it was located. On 03/21/19 in the morning, the Administrator arrived to the facility. The Administrator was unaware a staffing schedule was required. The Administrator indicated the facility kept time cards for Employee #2, which listed Employee #2's schedule. The Administrator explained the Administrator and Employee #4 were owners and were at the facility all of the time. The Administrator explained Employee #3 worked at the facility as a Caregiver. The Administrator acknowledged the facility lacked documented evidence of a staff schedule, which included the number and types of staff members assigned to each shift. Review of facility documentation lacked documented evidence a staff schedule, which included the number and types of staff members assigned to each shift, was completed. Severity: 2 Scope: 1	0088	Tag0088: Prime Care Facility has a written weekly time card that indicants the days and hours staff works. The time card is never locked away. It is always located in the office on the office table. As an owner and officer of the facility, I have never completed a weekly time card, however now that I am aware that HCQC requires me to do so I have been filling it out. See attachment. All clients in this facility attend day program Monday through Friday from 8:30 AM to 3:00 PM. During this time staff number 3 has permission to leave the facility and be back at 2:30 PM, before the clients arrive back.	04/29/2019

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0430 SS= D	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure smoke detectors were documented as being tested on a monthly basis. Findings include: On 03/21/19 at 9:00 AM during a facility tour, smoke detectors were observed throughout the facility. Review of facility documentation, revealed the facility lacked documented evidence the facility tested the smoke detectors on a monthly basis. On 03/21/19 at 4:00 PM, the Administrator indicated the smoke detectors in the facility worked and Employee #4 checked them monthly. The Administrator acknowledged the facility lacked documented evidence the facility tested the smoke detectors on a monthly basis. Severity: 2 Scope: 1	0430	Tag 0430: Prime Care Facility has a monthly smoke detector check up. When the inspector visited my facility on 03/21/2019, the paperwork has not updated for two months. Since the inspector's visit, the administrator has updated the monthly smoke detector check up. To prevent this issue from occurring again, I have created a monthly to do list that includes checking and documenting the smoke detector. This to do list will be checked and signed the administer and staff. See attachment.	04/29/2019
0515 SS= E	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on interview, record review and document review, the facility failed to ensure 1 of 6 sampled	0515	Tag 0515: On 02/05/2019 Resident six asked for permission to stay overnight at a friend's house. The case coordinator gave permission for the resident to do so, but specified that he must have his medications during his stay. Resident six was given his evening medications. He informed staff three that he would be back in the morning for his AM medications and to eat breakfast, however he did not show up. Instead, he called staff three and demanded for his	06/10/2019

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	residents (Resident #6), who was noncompliant with the rules established by the Administrator for leaving the facility, was provided protective supervision. Findings include: Resident #6 (R6) R6 was admitted on 11/01/17 with diagnoses including schizoaffective disorder, history of asthma, history of falls and chronic pain. An Ultimate User Agreement dated 11/01/17, documented R6 approved the facility to administer R6's medications. A Treatment Plan dated 08/14/18, documented R6 needed consistent administration of behavioral health medications to maximize safety, stability and independence. A History and Physical dated 12/12/18, documented the plan for R6 was continued care at group home with prevented adverse medication events. A Medication Administration Record (MAR) dated February 2019, documented R6 was out and had not received morning medications including Sertraline 100 milligrams (mg) take one tablet by mouth daily and Sertraline 50 mg take one tablet by mouth daily. A facility document entitled House Policy and Regulations (undated) revealed house curfew was 10:00 PM every night. Doors would be locked at 10:00 PM. Unless approved by the staff, any resident returning after 10:00 PM would have found other sleeping arrangements for the night. Failure to return by curfew resulted in discharge from the home. On 03/21/19 in the morning, the Administrator explained on 02/26/19 in the evening, R6 went out to a friend's home. The Administrator indicated R6 called the Administrator in the evening and indicated R6 wanted to stay overnight at the friend's home and the Administrator approved this. The Administrator indicated R6 was supposed to return to the facility on 02/27/19 for morning medications to be administered. The Administrator indicated R6 did not return to the facility and instead went straight to R6's day program. The Administrator indicated R6 called the facility and spoke to a Caregiver. R6 requested the		medication to be given to another resident. He wanted the resident to bring his medication to Mojave's Day Program, where he currently was at. Staff three did not inform the administer of this. Instead, she followed the demands of resident six. She later told the administrator that she was afraid because resident six was acting extremely aggressive on the phone. Five days after this incident, the administer received a certified mail from SNANHS stating what had occurred. I spoke to staff three and explained why she cannot do what she did. Prime Care Facility will not tolerate this incident. Staff three was given disciplinary action. See attachment. Prime Care Facility created a client over night policy to ensure that we follow the regulation of HCQC. There is a form needed to be filled out 3 days before the client stays over night so the Case Coordinator is aware and approves. See attached: Over night policy, over night form.	

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	Caregiver send a resident to the day program to deliver R6's morning medications. The Caregiver sent R4 to R6's day program to deliver R6's morning medications. The Administrator indicated the Administrator found out later the reason R6 had called to request permission to stay overnight at a friend's home on 02/26/19 was because R6 had smoked marijuana and had not wanted to return to the facility. The Administrator indicated the Administrator had spoken to R6 about the curfew policy and ensuring R6 was available at the facility for medication administration. The Administrator indicated the incident involving R6 had occurred once. The Administrator explained the Administrator spoke to the Caregiver who allowed R4 to drop off R6's medications and explained to the Caregiver it was not allowed because R6 had signed an Ultimate User Agreement for the facility to administer medications. The Administrator and Employee #4 acknowledged there were several risks to R4 and R6 when R4 delivered R6's medications. The Administrator and Employee #4 explained R4 could have taken, sold or lost R6's medication and had an adverse outcome. The Administrator and Employee #4 explained R6 could have sold or lost the medication. The Administrator and Employee #4 acknowledged R6 missed the curfew time of 10:00 PM on 02/26/19. The Administrator and Employee #4 acknowledged R6 should have returned to the facility the morning of 02/27/19 for administration of morning medications. The Administrator and Employee #4 acknowledged the Caregiver should not have allowed another resident to deliver R6's morning medication because it was a safety issue and there was an Ultimate User Agreement for R6. The Administrator indicated if a Caregiver or the Administrator were unavailable to deliver R6's medications, the nurse should have been notified. The Administrator indicated the			

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	facility should have contacted a nurse regarding the missed morning medications. The Administrator acknowledged the incident was not reported to the case manager. The Administrator acknowledged there was a lack of documented evidence of the incident and whether the facility notified the physician. A facility policy entitled Incident Reporting for Residents and Employees (undated), documented an incident was an unusual occurrence which was not consistent with the routine operation of the community or routine care of a particular resident, resulting in potential injury to the resident. The procedure was to have completed an Incident Report Form and faxed it to the case manager. Severity: 2 Scope: 2 Complaint #NV00056091			

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0859 SS= D	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 care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to ensure 1 of 6 sampled residents (Resident #3) received an annual physical examination. Findings include: Resident #3 (R3) R3 was admitted on 07/15/12 with diagnoses including schizophrenia. R3's medical record revealed A History and Physical dated 10/11/17. R3's medical record lacked documented evidence an annual physical examination was completed. On 03/21/19 at 3:30 PM, the Administrator indicated R3 should have had an annual physical examination. The Administrator acknowledged an annual physical examination was not completed and on file in R3's medical record. Severity: 2 Scope: 1	0859	Tag 0859: Resident three had a physical examination on October 15, 2018. The doctor's office did not mail this examination to the facility. The facility contacted the doctor's office on numerous occasions to retrieve these documents. Each time the office was contacted they reassured the administrator that the document would be sent, however they never were. During the last contact with the doctor's office, the receptionist informed the administrator that the doctor had left for vacation and would not be back for 3 weeks. When the doctor came back from vacation, the administrator picked up the document's from the office. See attachment. To prevent this from occurring again, Prime Care facility has created a check list to verify that all residents' documents are up to date.	04/29/2019
0871 SS= D	Medication Administration - Plan - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which	0871	Tag 0871: On March 19, 2019 Resident two missed his blood work at Mojave for clozapine levels. The staff took resident two to Mojave, however instead of sitting in the waiting room, he decided to wonder around the vicinity of Mojave. As a result, the phlebotomist left without giving him his blood work. The next day, the nurse at Mojave provided me with a blood work referral to Quest Diagnostic for resident two. There, resident two was able to get his blood work completed. On March 21, 2019, the inspector visited the facility in the morning. She saw that his resident's bottle	04/29/2019

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	ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician or other physician of the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure their policy on refilling medication in a timely manner was followed for 1 of 6 sampled residents (Resident #2). Findings include: Resident		for clozapine was empty. I explained to the inspector that the blood work results have not been sent to the pharmacist yet. The pharmacist will not refill the medication without the results. Before the inspector left the facility, staff picked up resident's two clozapine refill. Prime Care Facility created a medication refill procedure. The medication refill procedure will be posted so the staff and administrator will be aware when to fill the medication properly. The reason for the refill procedure is so the incident will not happen again. Prime Care Facility created medication refill form. Staff will fill out the form and fax needed medication to the pharmacy. See medication refill procedure and medication refill form.	

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	#2 (R2) R2 was admitted on 07/13/01 with diagnoses including chronic schizoaffective disorder. An Ultimate User Agreement dated 07/13/01, documented R2 required medication administration. A Medication Review dated 02/27/19, documented R2 was administered the following medications: Clozapine 100 milligrams (mg) one tablet by mouth in the morning and two tablets by mouth at bedtime; and Clozapine 25 mg one tablet by mouth at bedtime. On 03/21/19 in the afternoon, R2's medication container was observed. A medication bottle had a label which read Clozapine 100 mg one tablet by mouth in the morning and two tablets by mouth at bedtime. A second medication bottle had a label which read Clozapine 25 mg one tablet by mouth at bedtime. Both medication bottles were empty. The container held no other medication bottles of Clozapine. On 03/21/19 in the afternoon, the Administrator acknowledged the bottles of Clozapine 100 mg and Clozapine 25 mg were empty. The Administrator explained the last pill of Clozapine 100 mg was administered on 03/21/19 in the morning and the last pill of Clozapine 25 mg was administered on 03/20/19 at bedtime. The Caregiver indicated the pharmacist had been notified on 03/20/19 a refill of Clozapine 100 mg and Clozapine 25 mg were needed for R2. The Administrator explained the facility had a policy for ensuring medication was ordered timely. The Administrator indicated the standard for ordering medication timely was at least two days in advance. The Administrator indicated the facility had not followed their medication policy for ensuring a resident's medication was ordered per the facility policy. Severity: 2 Scope: 1			
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the	0876	Tag 0876 Resident #6 - Pain medication was prescribed 3x a day. On the MAR it was written 2x a day because the resident wants to use the medication 2x a day, he does not want to bring to the day program. Prime Care Facility staff explained to him that we have to follow the doctors	04/29/2019

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	administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure an ultimate user agreement was followed for 1 of 6 sampled residents (Resident #6). Findings include: Resident #6 (R6) R6 was admitted on 11/01/17 with diagnoses including chronic pain. On 03/21/19 at 9:00 AM during a facility tour, R6 was not observed in the facility. On 03/21/19 at 9:00 AM, a Caregiver indicated R6 attended a day program. On 03/21/19 at 12:00 PM, the Administrator indicated R6 was still at the day program. On 03/21/19 in the afternoon, a bottle with a label that read SHR Arthritis Pain 650 milligrams (mg) take one tablet by mouth three times daily was observed in R6's medication container. An Ultimate User Agreement dated 11/01/17, documented R6 approved the facility to administer R6's medications. A Treatment Plan dated 08/14/18, documented R6 needed consistent administration of behavioral health medications to maximize safety, stability, independence and to determine their effectiveness/necessity. A History and Physical dated 12/12/18, documented the plan for R6 was continued care at group home with prevented adverse medication events. A Medication Administration Record (MAR) dated March 2019, documented R6 received the SHR Arthritis Pain medication at 8:00 AM, noon, and 8:00 PM. On 03/21/19 in the afternoon, the Administrator acknowledged the MAR for March 2019 documented R6 received the SHR Arthritis Pain medication at 12:00		order/prescription. Staff explained that he has to sign, refused, if he does not take the noon time medication. Prime Care Facility will follow the doctors order and what ever the doctors order will be written on the MAR. Prime Care Facility created a medication Administrating policy. This policy shows how to administrate the medication indication how the drugs moves through your body when administrator and possible side effects, dangerous reaction, possible storage and disposable. See attached documents.	

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	PM. The Administrator explained R6 took the medication with R6 to the day program to administer. R6's medical record lacked documented evidence R6 self-administered medications. The Administrator indicated R6 was not capable of self-administering medications due to R6's diagnoses. The Administrator acknowledged R6 had signed an ultimate user agreement authorizing staff at the facility to administer medications. The Administrator acknowledged the staff were not following the ultimate user agreement by allowing R6 to administer R6's medications. The Administrator indicated the facility procedure for administration of medications when a resident left the facility was to provide the family member or caretaker the resident's medications for administration. The Administrator acknowledged a Caregiver should have administered R6's medications. Severity: 2 Scope: 1			
0878 SS= E	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 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)	0878	Tag #0878 Resident #1 - Medication (Sertraline 100mg) bottle was empty when inspector came March 21. The medication was no refill. The pharmacy requested a refill from the doctor. The medication was refilled that day. The staff and administrator will check the medication daily so this incident will not occur again. Resident #5 - Medication (Famotidine 20mg) bottle was empty when inspector came March 21. The medical doctor came to the facility March 20 and gave medical check up to Resident #1 and prescribed Famotidine. Medication was filled that day before the inspector left. Prime Care Facility checks daily Resident(s) medication. A check medication form was created so the faculty will be aware what medication needs to be filled. The administrator explained to the staff 2 to 3 days before the due date the medication can be filled. Resident #6 Medication (Sertraline 100 mg and 50 mg) was not given because the	04/29/2019

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		A. BUILDING _____ B. WING _____	**03/21/2019**

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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	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 observation, interview and record review, the facility failed to administer medication as prescribed for 3 of 6 sampled residents (Resident #1, Resident #5 and Resident #6). Findings include: Resident #1 (R1) R1 was admitted on 08/01/08 with diagnoses including schizoaffective disorder. On 03/21/19 in the afternoon, R1's medication container was observed. A medication bottle had a label which read Sertraline 100 milligrams (mg) one tablet by mouth twice a day. Medication was in the bottle. An Ultimate User Agreement dated 08/01/08, documented R1 required medication administration. A Medication Review dated 02/27/19, documented R1 was administered Sertraline 100 mg one tablet by mouth twice a day. A Medication Administration Record (MAR) dated March 2019, documented Sertraline 100 mg was not administered on 03/05/19 at 8:00 PM and on 03/06/19 and 03/07/19 at 8:00 AM and 8:00 PM. On 03/21/19 in the afternoon, the Administrator acknowledged R1 received Sertraline 100 mg twice daily. The Administrator explained on 03/05/19, 03/06/19 and 03/07/19, the medication had not been received by the		MAR had no signature. Staff #3 stated that all medication was given. She explained the client did not sign the MAR. Administrator stated to staff that the MAR must be signed daily and checked daily.	

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	pharmacy and was unavailable to administer to R1. The Administrator acknowledged Sertraline 100 mg was not administered as prescribed. Resident #5 (R5) R5 was admitted on 12/12/18 with diagnoses including schizophrenia. On 03/21/19 in the afternoon, R5's medication container was observed. A medication bottle had a label which read Famotidine 20 mg one tablet by mouth twice a day. The bottle was empty. A treatment plan dated 03/20/18, documented R5 needed consistent administration and assistance with behavioral health medication to maintain stability within the community. An Ultimate User Agreement dated 12/12/18, documented R5 required medication administration. A Medication Review dated 03/01/19, documented R5 was administered Famotidine 20 mg one tablet by mouth twice a day. A Medication Administration Record (MAR) dated March 2019, documented Famotidine 20 mg was not administered on 03/21/19 at 8:00 AM. On 03/21/19 in the afternoon, the Administrator acknowledged R5 received Famotidine 20 mg twice daily. The Administrator explained on 03/21/19 at 8:00 AM, the medication had not been received by the pharmacy and was unavailable to administer to R5. The Administrator acknowledged Famotidine 20 mg was not administered as prescribed. Resident #6 (R6) R6 was admitted on 11/01/17 with diagnoses including schizoaffective disorder. On 03/21/19 in the afternoon, R6's medication container was observed. A medication bottle had a label which read Sertraline 100 mg one tablet by mouth daily. Another medication bottle had a label which read Sertraline 50 mg one tablet by mouth daily. A treatment plan dated 03/20/18, documented R6 needed consistent administration with behavioral health medication to maximize safety, stability, independence and to determine effectiveness/necessity. An Ultimate User Agreement dated 11/01/17, documented R6 required medication administration. A			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	Medication Review dated 12/12/18, documented R6 was administered Sertraline 100 mg one tablet by mouth daily and Sertraline 50 mg one tablet by mouth daily. A Medication Administration Record (MAR) dated February 2019, documented R6 was out and Sertraline 100 mg and Sertraline 50 mg were not administered on 02/27/19 at 8:00 AM. On 03/21/19 in the morning, the Administrator acknowledged R6 received Sertraline 100 mg and Sertraline 50 mg daily at 8:00 AM. The Administrator explained on 02/27/19 at 8:00 AM, R6 was at a day program and had not received the medication at 8:00 AM. The Administrator acknowledged Sertraline 100 mg and Sertraline 50 mg were not administered as prescribed. Severity: 2 Scope: 2 Complaint #NV00056091			
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to	0938	Tag #0938 Resident #3 has an annual ADL assessment was completed Dec. 17, 2018. Finally the facility was able to get the packet annual ADL assessment from the doctor. The facility created resident check list so this issue will not occur again. See Document Prime Care Facility created, clients medical record, so staff will be aware what documents of a resident needs to be renewed. And staff will be aware of expired documents. See attached medical record policy and resident check list.	04/29/2019

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	ensure an Activities of Daily Living (ADL's) Assessment was completed annually for 1 of 6 sampled residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 07/15/12 with diagnoses including schizophrenia. On 03/21/19 at 9:00 AM, a Caregiver indicated R3 walked with a cane. The Caregiver indicated R3 walked with a cane because another resident walked with a cane and R3 wanted a cane also. On 03/21/19 in the afternoon, the Administrator indicated R3 was receiving home health services and was unaware of the reason. Review of R3's medical record revealed the last annual ADL's assessment was completed on 10/11/17. R3's medical record lacked documented evidence an annual ADL's assessment was completed. On 03/21/19 in the afternoon, the Administrator indicated an annual ADL's assessment should have been completed for each resident to determine the level of assistance required for ADL's. The Administrator acknowledged R3 did not have an annual ADL's assessment completed. Severity: 2 Scope: 1			