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
	3483	A. BUILDING _____ B. WING _____	11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE	1905 S 17TH STREET, LAS VEGAS, NEVADA ,89104

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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 11/27/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was seven. Seven resident files were reviewed and five employee files were reviewed. The facility received a grade of A. 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 deficiencies were identified:	0000		

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0105 SS= D	449.200(1)(f) - Personnel File - Background Check - NAC 449.200 Staffing requirements; limitations on number of residents; written schedule required for each shift. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 employees met background check requirements of NRS 449 (Employee #5). Findings include: On 11/27/17, a review of employee files revealed the following: Employee #5 Employee #5 was hired as a caregiver on 05/01/17. The file lacked proof of fingerprinting or background check determination indicated from the Nevada Automated Background Check System (NABS). Search for Employee #5 on the NABS system revealed no application or fingerprinting completed. On 11/27/17 in the morning, the Owner acknowledged the deficiency and reported Employee #5 had lost their identification and had not been fingerprinted. Severity: 2 Scope: 1	0105	1.) Employee #5 already resign as of 11/29/2017. 2.) This facility will review all employee record checklist together with the actual employees file. 3.) By this way facility will be able to track missing documents that needs to be done & file. 4.) Administrator will monitor.	11/29/2017

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0693 SS= D	449.2712(2) - Oxygen-Caregiver monitor resident ability - NAC 449.2712 Residents requiring the use of oxygen. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to secure oxygen tanks in 1 of 5 resident rooms. Findings include: On 11/27/17, during a tour of the facility observed eleven small oxygen tanks unsecured in the bedroom closet of Resident # 3. On 11/27/17 in the morning, the Owner acknowledged the observations and reported they would secure the tanks. Severity: 2 Scope: 1	0693	1.) Immediately put all eleven small oxygen tank in the crate & secure it with bungee cord. 2.) This facility will make sure that all oxygen tank must be secured at all times and by conducting a monthly touring around each residents bedroom closet. 3.) A monthly Calendar was made to remind upcoming task & making sure task was done. 4.) Facility manager or owner monitor.	11/27/2017
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	0878	1.) Immediately corrected Medication Administration Review Sheet (MARS), medication records in both Resident #2 & Resident #4 are now current. 2.) Facility must review all new medication orders & be written at MARS exactly as it is written & provided residents exactly the same as the physician order is written. Also all medication that are discontinued must be taken out from MARS in order to be current with physician order.	11/28/2017

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	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) 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, record review, and interview, the facility failed to ensure medications were available on site and/or administered as prescribed for 2 of 7 residents. (Residents #2 and #4) Findings include: On 11/27/17, review of the resident files, medications and Medication Administration Records(MAR) revealed: Resident #2 Resident #2 was admitted on 06/03/11 with a diagnoses including hypertension and acid reflux. Review of resident's records revealed a physician order dated 11/02/17 for Ducosate 100 milligram(mg), take one capsule by mouth twice daily and a physician order dated 11/10/17 for Ducosate 100 mg, take one capsule by		3.) This facility will make sure of the veracity of the medication order & be written at the MARS correctly. 4.) Administrator will monitor.	

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	mouth twice daily as needed. Review of the November 2017 MAR revealed the medication had not been administered as prescribed from 11/02/17 to 11/09/17. On 11/27/17 in the afternoon, the Owner acknowledged the resident had not received the medication as scheduled prior to the order change to as needed basis. Resident #4 Resident #4 was admitted on 01/30/16 with diagnoses including chronic knee pain, depression, debility and hypertension. Review of resident's records revealed a physician order dated 09/27/17 for Temazepam 7.5 mg, one tab every night at bedtime as needed for insomnia. Review of the November 2017 MAR which documented Temazepam 7.5 mg, take one capsule by mouth every night at bedtime as needed for insomnia. The MAR had no documentation that the medication had been administered. On 11/27/17 in the afternoon, the Owner acknowledged the medications were not on site. Severity: 2 Scope: 2			

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0920 SS= F	449.2748(1-2) - Medication Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 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. Medication 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 without supervision may keep his medication in his 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 stored and secured in a locked area. Findings include: On 11/27/17, the following medications were discovered unsecured: During medication review, Resident #3's Pro Air HFA inhaler was not present in the medication bin. The resident authorized the facility to manage and administer their medication. The Owner reported the resident feels anxious and likes to keep it with them and retrieved the medication from the resident. Resident #3's file lacked a prescription order indicating the resident could manage and administer the inhaler independently. On 11/27/17 in the morning, the Owner acknowledged the medication was unsecured and reported they would request an order from the physician indicating the resident may self administer the medication. Severity: 2 Scope: 3	0920	1.) Immediately employee #3 purchase a small box with lock, in order to put in Resident #3 Pro Air HFA inhaler. 2.) Resident #3 physician provided an order that Residents #3 may have Pro Air HFA inhaler by bedside. 3.) This facility will always follow appropriate training techniques use in medication training. 4.) Facility manager/ owner will monitor.	11/28/2017