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 _____ | **05/05/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **SAINT ANNE RESIDENTIAL CARE CORP** | **3158 KINGSPOINT AVENUE, LAS VEGAS, NEVADA ,89120** |

| (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 |
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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 05/05/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The census at the time of the survey was 9. The sample size was five. Five resident files and three employee files were reviewed. The facility received a grade of A. There were three complaints investigated. Substantiated: 1. Complaint # NV00072866 was substantiated. (See TAG Y0878) 2. Complaint #NV00073787 was substantiated. (See TAG Y0565) Unsubstantiated: 3. Complaint # NV000773668 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observations of the food in the facility, medications, interactions between staff and residents, meal observation, and a tour of the facility. Interviews were conducted with the Residents of Concern, residents, caregivers, the facility manager, and the Administrator. Clinical Record Review of five records, which included the residents of concern. Document review included physician orders, medication adminsitration records, facility policies, the admission agreement, a resident of concern's banking statements and menus. 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 investigation, 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: VISITACION DELA PENA | Title: Administrator | Date: 06/04/2025

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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| 0565 SS= D | Money and Property of Residents - NAC 449.267 Money and property of residents. (NRS 449.0302) 1. An employee of a residential facility shall not handle a resident ' s money without first being requested to do so in writing by the resident or his or her representative.<br><br>Inspector Comments: Based on interview and record review, the facility failed to ensure a written agreement between the facility and the resident and/or resident's responsible party was completed prior to the facility's Manager handling 1 of 5 resident's money (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 06/14/24 with diagnoses including myocardial infraction and prostate cancer. R1's November 2024 checking account statement documented on 11/01/24 a $11.34 transaction occurred at a local smoke shop using R1's debit card. R1's December 2024 checking account statement documented on 12/06/24 a $8.26 transaction occurred at a local smoke shop and on 12/09/24 a $15.98 transaction occurred at a local discount store using R1's debit card. R1 reported the Manager helped R1 with R1's finances and verbalized asking the Manager to purchase the cigarettes. On 05/05/25 in the morning, the Manager verbalized R1 gave the facility verbal permission to utilize R1's debit card to purchase R1's tobacco and other personal items. The Manager confirmed they would purchase items R1 requested such as tobacco, personal items and soda with R1's debit card since July 2024. The Manager acknowledged the facility did not have written permission from R1 to utilize the debt card. Severity: 2 Scope: 1 Complaint #NV00073787 | 0565 | Tag 0565<br><br>1. To correct the specific finding stated in the SOD, R1 provided a written agreement to authorize E2 or any staff to purchase his needs along with a written request and his signature for all receipts acquired.<br>2. To ensure that the deficient practice will no longer recur, the staff should make sure all transactions are signed, recorded and documented for every resident's financial transactions to avoid misconceptions of financial exploitation.<br>3. Document all financial activities and make sure the residents sign authorization letter.<br>4. The Administrator and staff must ensure that proper documentation will be done whenever there will such kind of activities going on.<br>5. Corrected : 05/31/2025 | 05/31/2025 |
| 0878 SS= E | Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the- | 0878 | Tag 0878<br><br>1. To correct the specific findings of the SOD, the staff incharge will pay extra careful in reconciling Doctor's order to the | 05/31/2025 |

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| | counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. 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, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse 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, physician assistant or advanced practice registered nurse 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, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, | | MAR.<br>2. To avoid recurrence of the deficiency, double checking and reconciling of the MAR to the doctor's orders and with medicine bottle.<br>3. Thorough reconciliation of MAR-Doctor's Order-Medicine bottle and record will be checked and rechecked to avoid for the deficiency to recur.<br>4. The Administor and E2 will ensure that the plan of correction is implemented.<br>5. Completed: 05/31/2025 | |

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| | 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.<br><br>Inspector Comments: Based on record review and interview, the facility failed to follow the physician orders as prescribed for 1 of 5 sampled residents (Resident #4). Findings include: Resident # 4 (R4) R4 was admitted on 11/26/24 with diagnoses including cardiovascular accident and hemiparesis following a cerebral infarction. R4's November 2024 MAR documented Gabapentin 300 milligram (mg) capsules, take one capsule by mouth three times daily. Per documentation on the MAR, Gabapentin was given at 7:00 AM and 7:00 PM only, on 11/26/24 through 11/30/24. Medication lists dated 01/30/25, 02/17/25, and 03/31/25, and an undated Acute Care Patient Summary, document Gabapentin 300 mg capsules three times daily. On 05/05/25 in the morning and afternoon, E2 acknowledged inaccuracies on the MAR. Severity: 2 Scope: 1 | | | |
| 0895 SS= E | Administration of Medication Maintenance - NAC 449.2744 and R043-22 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; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine | 0895 | Tag 0895<br><br>1. To correct the SOD, the staff incharge will pay extra careful in reconciling and transcribing the MAR and any changes will be transcribed immediately and monthly audit of the resident's Medications is a must. R1 and R4's MAR were corrected.<br>2. MAR should be reconciled, medications should be audited monthly and reconciled with doctor's order and bottle instructions.<br>3. To prevent from the deficient practice to recur, the Administrator will make sure that the MAR, Medicine bottles, doctor's order are properly reconciled every end of the month.<br>4. The Administrator and the staff incharge of the MAR will make sure that the plan of correction is implemented.<br>5. Corrected: 05/31/2025 | 05/31/2025 |

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| | schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication.<br><br>Inspector Comments: Based on observation, record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 5 sampled residents (Residents #1 and #4). Findings include: Resident #1 (R1) R1 was admitted on 06/14/24 with diagnoses including prostate cancer and myocardial infarction. A physician order for R1 dated 12/16/24 documented Trazadone 150 milligrams (mg) by mouth at bedtime. R1's medication bin contained Trazadone 150 mg tablet, Take one tablet by mouth every night at bedtime, dated 04/23/25. R1's May 2025 MAR lacked documented evidence Trazadone was administered to R1. On 05/05/25 at 12:10 PM, E2 reported that they administered Trazadone to R1. A physician order for R1 dated 03/10/25 documented: Discontinue scheduled Alprazolam one mg; change Alprazolam to one mg by mouth at bedtime as needed. R1's medication bin contained Alprazolam 1 mg tablet, generic for Xanax, take one tablet by mouth every night at bedtime, dated 03/25/25. The medication bottle lacked a change order label. Alprazolam was not documented on R1's May 2025 MAR. On 05/05/25 at 12:10 PM, E2 verbalized that they needed to put Alprazolam back on the MAR. Resident # 4 (R4) R4 was admitted on 11/26/24 with diagnoses including cardiovascular accident and hemiparesis following a cerebral infarction. R4's May 2025 MAR documented Carvedilol 6.25 mg tablet, take one tablet by mouth with breakfast and with evening meal. Per R4's May 2025 MAR, Carvedilol was administered 05/01/25 through | | | |

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| | 05/04/25 in the evening only. On 05/05/25 at 11:45 AM, E2 explained they gave R4 Carvedilol both mornings and evenings, as per the physician order, because "BID" (two times a day) was written on the bottle cap. E2 admitted they overlooked their incorrect documentation on the May MAR . R4's medication bin contained Mirtazapine 7.5 mg tablet, take one tablet by mouth every night at bedtime, dated 05/02/25. Mirtazapine was not documented on R4's May 2025 MAR. On 05/05/25 at 11:55 AM, E2 explained they missed writing Mirtazapine on the May MAR because the medication was new. E2 said they administered Mirtazapine to R4 as soon as it arrived at the facility. E2 admitted they needed to write Mirtazapine on the May 2025 MAR. Severity: 2 Scope: 2 | | | |