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
	3847	A. BUILDING _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER DAYS GROUP HOME	**261 E ELDORADO LANE, LAS VEGAS, NEVADA ,89123**

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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of the Re-grading State Licensure survey conducted at your facility on 09/10/19, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for persons with mental illness and/or chronic illness, three Category 1 and seven Category II residents. The census at the time of the survey was 8. Eight resident records and two employee records 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 regulatory deficiencies were identified:	0000		

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0820 SS= D	449.2734(1)(a-c) - Tracheostomy / Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by a medical professional; residents having pressure or stasis ulcers. 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance. (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care. (c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. Inspector Comments: Based on interview and record review, the facility failed to request a written exemption to admit and retain a resident with an open wound for 1 of 8 sampled residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 08/09/19 with diagnoses including hypertension and atherosclerotic heart disease. R2 began receiving hospice services effective 08/07/19. On 09/10/19 at 10:45 AM, a Caregiver indicated R2 had an open wound on the buttocks which was being treated by the Hospice Nurse. The Caregiver indicated R2 was admitted to the facility with the open wound. On 09/10/19 at 11:00 AM via telephone, the Hospice Nurse verified there was an open wound on the buttocks. The Hospice Nurse verbalized she was unsure whether it was in a healing condition, and whether the wound had progressed to a stage 3. On 09/10/19 at 3:00 PM, the Administrator indicated he was unaware the facility needed to submit a written exemption request for a resident with an open wound. Severity: 2 Scope: 1	0820	1. We will be more aware when accepting a new resident with any open wounds to make sure to get a waiver. 2. We will put in our assessment regimen to make sure we ask and observe resident. 3. We will ensure to add it to our Physician report to indicate if there are any open wounds 4. The Administrator will monitor this action, when he goes out to assess a potential resident. 5. Sept. 11, 2019 6. Attached is the order regarding R1 attached is Wound care waiver	09/11/2019

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0876 SS= D	449.2742(4) - Medication Administration NRS 449.0302 - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. Inspector Comments: Based on interview and record review, the facility failed to provide a written ultimate user agreement for 1 of 8 sampled residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 08/09/19 with diagnoses including atherosclerotic heart disease and hypertension. On 09/10/19 at 10:00 AM, there were 11 medications in R2's medication bucket. There was no documented evidence of a written ultimate user agreement for R2. On 09/10/19 at 10:15 AM, the Caregiver verified R2's chart lacked a written ultimate user agreement. Severity: 2 Scope: 1	0876	1. We will make sure when accepting a new resident that all paperwork will be on hand. 2. We will make sure all paperwork will be put together so not to forget any documentations 3. We will have a checklist when admitting new residents to ensure all paperwork is filled up 4. Manager of facility will ensure all paperwork is there, there should be an audit done at least 2 days after admission. 5. Sept. 12, 2019 6. attached is Med Mgmt Agreement	09/12/2019
0878 SS= D	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 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	0878	1. The specific medication orders were clarified by the physician and the medication for R1 and R4 are now being administered appropriately per physician's order. 2. We will ask our visiting Nurse Practitioner to retrain us on verbiage towards medications 3. We have to retrain ourselves to be more aware of what the Physician ordered and if we don't understand we must contact physician to know exactly what the order asks for. We will retrain caregivers and ourselves . 4. The Administrator will ensure that we are retrained and understand what each medication is called for. 5. Sept. 28, 2019 6. attached an order	09/28/2019

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	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 interview and record review, the facility failed to ensure medications were administered per physician's orders for 2 of 8 sampled residents (Resident #1 and #4). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/29/19 with diagnoses including cardiomyopathy and coronary artery disease. R1 was receiving Hospice services upon admission. The medication bucket for R1 contained Acetaminophen, 236 milligrams (mg), 2 tablets twice daily; and Senna, 8.6 mg, 1 tablet each day. The Medication Administration Records (MAR's) for June, July, August, and September 2019 did not document the Acetaminophen was administered twice daily and the Senna was administered daily. On 09/10/19 at 10:00 AM, the Caregiver indicated he misunderstood that the medications were supposed to be administered daily. The Caregiver indicated he thought the medications were ordered to be given as needed. The Caregiver verified the Acetaminophen and the Senna should have been administered on a routine, daily basis. Resident #4 (R4) R4 was admitted to the facility on 02/28/17 with diagnoses including diabetes mellitus, hypertension, and			

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	coronary artery disease. The MAR's documented the following medications which were not administered per physician's instructions: 1. Atropine Sulfate 1%, dispensed on 08/12/19, place 2 drops by mouth sublingually every morning and every 2 hours as needed for secretions. There was no evidence on the MARs for August and September 2019 that the Atropine was administered every morning per the physician's instructions. On 09/10/19 at 11:00 AM, two Caregivers verified they did not administer the Atropine every morning per the physician's instructions. The Caregivers indicated they misunderstood the physician's instructions that the Atropine was supposed to be administered routinely every morning. The Caregivers indicated they thought the Atropine was only supposed to be administered as needed. 2. Risperidone, 0.25 mg, 1 tablet daily was documented on the September 2019 MAR. The Risperidone was being administered twice daily per the MAR (AM/PM). R4's medication bucket contained a bottle of Risperidone, which the label indicated was 1 mg, which was dispensed on 09/03/19. On 09/10/19 at 11:00 AM, the Caregiver indicated the 1 mg dosage was actually being administered two times daily. The Caregiver verified the MAR instructions and the physician's orders did not match. 3. Lorazepam, 0.5 mg, take 1 tablet every 8 hours for agitation. The September 2019 MAR lacked documentation the Lorazepam was administered routinely. On 09/10/19 at 11:00 AM, the Caregiver verified the Lorazepam should have been administered 3 times daily on a routine basis. The Caregiver indicated he thought the Lorazepam was only supposed to be administered on an as-needed basis. On 09/10/19 at 3:00 PM, the Administrator indicated the medications for R1 and R4 were not administered routinely because the Caregivers thought they were supposed to be given as needed. The Administrator verified the instructions were misread by the Caregivers. The Administrator indicated he left it up to the Caregivers to manage the medications, and did not audit the residents' medications to make sure medications were administered as ordered by the physicians.			

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	Severity: 2 Scope: 1			
0895 SS= D	449.2744(1)(b 1-4)+449.2746(2) - Medication / MAR-PRN MAR - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. 1. The administrator of a residential facility that provides assistance to residents in the administration of medication 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. NAC 449.2746 (Refer to NAC 449.2742(5) 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.) 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) 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 a caregiver documented the reasons and results for PRN (as-needed) medication for 3 of 8 sampled residents (Resident #1, #2, and #3). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/29/19 with diagnoses including cardiomyopathy and coronary artery disease. R1's medication bucket included Diphenhydramine, 25 milligrams (mg) and Haloperidol Concentrate, 1.5 milliLiter (mL) to be administered together, every 8 hours as needed for agitation. The Diphenhydramine and Haloperidol were	0895	1. We will retrain the whole staff to understand how important it is for the MARS to be correct 2. We will have training by our Nurse Practitioner to show the importance of indicating why we should document when giving PRN medications. 3. We will monitor MARS on a weekly basis, to make sure all is correct and done correctly 4. The Administrator will monitor this, Make sure all meds are given, whether they are routine or PRN and documented 5. Sept, 2019	09/28/2019

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	dispensed on 09/03/19. The Medication Administration Record (MAR) for R1 documented the Diphenhydramine and the Haloperidol were administered on 09/03/19 (once), 09/04/19 (once), 09/05/19 (twice), 09/06/19 (twice), 09/07/19 (twice), 09/08/19 (twice), and 09/09/19 (once). There was no documented evidence of the reasons and results of the medications. On 09/10/19 at 10:00 AM, the Caregiver verified he did not document the reasons and results of the Diphenhydramine and the Haloperidol administrations. Resident #2 (R2) R2 was admitted to the facility on 08/09/19 with diagnoses including hypertension and atherosclerotic heart disease. R2's medication bucket included Loperamide, 2 mg, 1 tablet every 8 hours as needed for loose stool. The MAR for September 2019 documented the Loperamide was administered daily on 09/01/19, 09/04/19, 09/05/19, 09/06/19, 09/07/19, and 09/08/19. There was no documented evidence of the reasons and results of the Loperamide. On 09/10/19 at 10:00 AM, the Caregiver verified he did not document the reasons and results of the Loperamide. Resident #3 (R3) R3 was admitted to the facility on 11/07/10 with diagnoses including Alzheimer's dementia, cerebrovascular disease, and hypertension. The MAR's for August 2019 documented Temazepam, 15 mg, 1 capsule at bedtime as needed for sleep. The Temazepam was administered on 09/04/19 and 09/05/19. There was no documented evidence of the reason and the results for the Temazepam. On 09/10/19 at 11:00 AM, the Caregiver verified he did not document the reason and the results of the administration of the Temazepam. On 09/10/19 at 11:00 AM, the Administrator indicated it was important to document the reasons and results of PRN medication. Severity: 2 Scope: 1 Repeat Deficiency: 03/08/19			

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0920 SS= D	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, interview, and record review, the facility failed to ensure medications were secured in a locked area. Findings include: On 09/10/19 at 10:30 AM, there was a container of D-Mannose with cranberry extract tablets on the dresser in a resident's room. The D-Mannose was not kept in a locked area. On 09/10/19 at 10:45 AM, the Caregiver verified the resident's daughter brought in the D-Mannose tablets and did not make sure they were secured because he thought the tablets were "candy". On 09/10/19 at 3:00 PM, the Administrator acknowledged all medications, including over-the-counter supplements, should be secured in a locked area. Severity: 2 Scope: 1 Repeat Deficiency: 03/08/19	0920	1. We will correct this finding by being more aware of what is given to our residents by family members. 2. We will educate and retrain our staff to monitor any form of "candy" or vitamin looking items to make sure we have a written order and placed in the appropriate place. 3. We will make sure to monitor all items with residents. Be more aware of medicine looking items are addressed. 4. The Administrator will make sure that this is implemented. Have meetings to retrain and to also monitor resident rooms 5. Sept 28, 2019	09/28/2019