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 _____	12/29/2022

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

(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 and infection control survey conducted at your facility on 12/29/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, 3 Category I residents and 7 Category II residents. The census at the time of the survey was 8. Eight resident files and six 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 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		

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 _____	12/29/2022

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

(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
0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her 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 record review, document review and interview, the facility failed to clarify the exact amount of medication to be administered for 1 of 9 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 01/13/20, with a diagnoses of diabetes, arthritis, and coronary artery disease. A physician's order dated 03/23/20 and R2's medication bottle, documented Acetaminophen 500 milligrams (mg) Take 1 -2 tablets by mouth every eight hours as needed (PRN) for pain. The Medication Administration Record (MAR) documented Acetaminophen mg Take 2 tablets by mouth every eight hours PRN for pain. The order was not clarified by the physician documenting the exact amount of medication to be administered to R2. The Owner verified with the nurse the order was not clarified and acknowledged the facility should have clarified how many tablets to give to R2. Severity: 2 Scope: 1	0905	1) In order to correct the findings the administrator contacted the resident's physician to clarify the exact amount of the medication to be administered. 2) To ensure the deficient practice does not recur the exact amount of medication to be administered will be clarified with the resident's physician. 3) To monitor that the deficient practice does not recur the administrator will review and clarify medication orders on monthly basis and when there is new medication ordered. 4) The administrator will be responsible for ensuring the plan of correction is implemented and that the exact amount of medication to be administered is clarified with the physician's order. 5) The corrective action was completed 12/29/2022.	12/29/2022

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 _____	12/29/2022

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

(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
0936 SS= E	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 9 residents had a tuberculosis (TB) test, per the requirement. Resident #3 was admitted on 01/27/20 and had no documented evidence of an annual TB test. Resident #3's last TB test was completed on 12/12/21. Resident #4 was admitted on 01/18/18 and had no documented evidence of an annual TB test. Resident #4's last TB test was completed on 10/08/21. Resident #5 was admitted on 01/31/22 with a first step TB test completed on 01/31/22. Resident #5's file lacked documented evidence a second step TB test was completed. Resident #6 was admitted on 10/28/18 and had no documented evidence of an annual TB test. Resident #6's last TB test was completed on 10/08/21. The Owner was unable to provide the missing TB test documentation and acknowledged the residents had not received TB testing, per the requirement. Severity: 2 Scope: 2	0936	1) To correct the specific findings stated in the statement of deficiencies, the required TB test were done to the 4 residents that did not meet the TB test requirements. 2) To ensure that all residents have the TB test per requirements, the facility will have a list of when the TB test are due for all residents. 3) The corrective action will be monitored by going over the list of the TB test due dates on monthly staff meetings. 4) The Administrator is responsible for ensuring the plan of correction is implemented. The administrator is responsible in ensuring that the TB test requirement is met by the residents. 5) The corrective action was completed 1/27/2023	01/27/2023

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 _____	12/29/2022

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

(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
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 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 449.122 to 449.125, inclusive. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 1 of 6 employees met the background check requirements of Nevada Revised Statute (NRS) 449.124 (Employee #5). Findings include: Employee #5 (E5): E5's personnel file documented fingerprints were last taken on 12/13/17. E5's personnel file lacked fingerprints for a five year renewal through the Nevada Automated Background Check System (NABS). The Administrator confirmed E5 had not completed the process for the five year renewal through NABS. Severity: 2 Scope: 1	0104	1) To correct the findings stated in the SOD that the facility failed to ensure that all employees met the background check requirements the facility suspended employee #5 until he completes the process for the five year renewal through NABS. 2) In order to ensure the deficient practice does not recur all employees will complete the process for the five year renewal through NABS. 3) To monitor and ensure that all employees met the background check requirements the administrator will confirm with NABS. 4) The administrator is responsible for ensuring the plan of correction is implemented and that all background check requirements are met by all employees and confirmed with NABS. 5) The corrective action was completed 12/13/2022	12/13/2022
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) Comply with the order; (2) Indicate on the container of the medication that a change	0878	1) To correct the specific findings stated in the statement of deficiencies, failing to have physician's order on-site and failing to give medication as prescribed, the facility contacted the physicians and obtained the physician's orders. 2) In order to ensure the deficient practice does not recur the facility will keep physician's orders on the resident's file. 3) Residents file will be checked during monthly staff meetings to monitor that physician's orders are on the resident's file and on-site. 4) The administrator will be responsible that the physician's orders are on-site and medications will be given as prescribed. 5) The corrective action was completed 1/5/2023	01/05/2023

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 _____	12/29/2022

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

(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
	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 record review, document review and interview, the facility failed to ensure there was a physician's order on-site for one resident's medication (Resident #1) and medication was administered per the physician's order for one resident (Resident #3). Findings include: Resident #1 (R1): R1 was admitted on 4/7/18 with diagnoses including hypertension and dementia. R1 was prescribed Loperamide 2 milligrams (mg) by mouth 1st loose stool then take 1 capsule by mouth subsequent stool not to exceed 8 capsules or 16 mg/24 hours. There was no physician's order on-site for the Loperamide. The Administrator verified there was no physician's order onsite for R1's medication Loperamide. A bubble pack labeled Metroprolol Suc 25 milligrams (mg) ER, Take 1 tablet by mouth every day was found in R1's medication bin. R1's file lacked documented evidence of a physician's order for the Metroprolol. The Administrator acknowledged there was no documented evidence of a physician's order for the Metropolol. Resident #3 (R3) R3 was admitted on 01/27/20, with diagnoses including arthritis. A physician's order dated 07/14/22, documented Betamethasone 0.05 percent. Apply topically to the affected area two times a day for two weeks then two times a day three times a week on Monday, Wednesday, and Friday. The December 2022 Medication Administration Record (MAR) documented the medication was			

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 _____	12/29/2022

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

(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
	given once a day every day. The Administrator acknowledged the medication was not given as prescribed. Severity: 2 Scope: 2			