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 _____	**05/30/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERESIANE ADULT GROUP CARE	**6620 ELLERHURST DRIVE, LAS VEGAS, NEVADA ,89103**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 5/30/19. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was ten. The sample size was five. There was one complaint investigated. Complaint #NV00057166 was substantiated. The allegation the resident was not administered a medication since being discharged from a local facility and medications were not administered as prescribed was substantiated (See TAG Y 871 and Y 878). The allegation the case manager and other facility staff were not notified of a resident's medication not available on site was unsubstantiated. The investigation into the allegations included: Observation of the medical condition of the other residents in the facility and five resident's medication bins containing medications. Interviews were conducted with five residents, the Administrator, a caregiver and the Pharmacy Manager. Review of five medical records including the resident of concern. Review of five Medication Administration Records including the resident of concern and the Medication plan policy. 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 deficiency were identified:	0000		
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	0871	a. Prior to admission, Management will ensure the validity of the prescription to prevent delay of the medication refill. Proper documentation will be noted in clinical notes for any action taken for future occurrence. The administrator/owner will	06/17/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARINA VAUGHN Title: ADMINISTRATOR Date: 06/21/2019

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	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 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		monitor for compliance. c. 06/17/2019	

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	attendance of caregivers. Inspector Comments: Based on record review and interview, the facility failed to ensure a medication was filled in a timely manner for 1 of 5 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted on 5/8/19, with a diagnoses including Schizophrenia. A physician order dated 5/7/19, documented the resident was prescribed Clozaril 50 milligrams (mg), take one tablet in morning and 75 mg tablet at night for psychosis. The Medication Administration Record (MAR) for May 2019, documented the resident was admitted on 5/8/19 at 2:00 PM. The resident was not administered Clozaril 50 mg or the 75 mg dose on 5/8/19, 5/9/19, 5/10/19, 5/11/19, 5/12/19, 5/13/19, 5/14/19 and the morning dose on 5/15/19. The Medication Log for May 2019, documented Clozaril 50 mg was delivered to the facility on 5/15/19. On 5/30/19 at 10:50 AM, the Pharmacy Manager explained the prescription was received at the pharmacy on 5/8/19. The prescription could not be filled due to the physician who prescribed the medications was not in the Risk Evaluation Mitigation Strategies (REMS) program. The Pharmacy Manager explained only physician's in the REMS program can write a prescription for Clozaril. The medication was not filled or delivered to the facility until 5/15/19. On 5/30/19 at 11:15 AM, the Administrator explained the resident was admitted on 5/8/19 without the medication Clozaril. The Administrator contacted the pharmacy and was informed the physician who prescribed the medications was not authorized to prescribed Clozaril. The Administrator explained the resident saw a physician on 5/9/19. The physician was made aware of the issue with the prescription. The Administrator thought the medication was going to be delivered on Friday 5/10/19, however the medication was not delivered. On 5/13/19 the resident started to become agitated. On 5/14/19 the Administrator			

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	explained to the case manager if the medication was not at the facility, 911 would need to be called. The medication was delivered on 5/15/19. Severity: 2 Scope: 1 Complaint #NV57166			
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 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	0878	a. Document under clinical notes the communication between the provider and facility. (SEE ATTACHMENT #1 0878). b. Orders will be obtained first prior to holding or changing any medication administration. The Administrator/Owner will monitor for compliance. c. 6/17/2019	06/17/2019

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	record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and interview the facility failed to ensure medications were administered according to physician's orders for 2 of 5 residents (Resident #1 and #2). Findings include: Resident #1 Resident #1 was admitted on 5/8/19 with a diagnosis of Schizophrenia. A physician order dated 5/7/19, documented the resident was prescribed Clozaril 50 milligrams (mg), take one tablet in morning and 75 mg at night for psychosis. The Medication Administration Record (MAR) for May 2019, documented the resident was admitted on 5/8/19 at 2:00 PM. The resident was not administered Clozaril 50 mg or the 75 mg dose on 5/8/19, 5/9/19, 5/10/19, 5/11/19, 5/12/19, 5/13/19, 5/14/19 and the morning dose on 5/15/19. On 5/30/19 at 10:50 AM, the Pharmacy Manager explained the order for Clozaril was sent to the pharmacy on 5/8/19. The medication was not able to be filled at that time and verified the prescription was not filled or delivered to the facility until 5/15/19. On 5/30/19 at 11:15 AM, the Administrator explained the resident was admitted on 5/8/19 without the medication Clozaril. The Administrator contacted the pharmacy and was informed the physician who prescribed the medications was not authorized to prescribed Clozaril. The Administrator explained the resident saw a physician on 5/9/19. The physician was made aware of the issue with the prescription. The Administrator thought the medication was going to be delivered on 5/10/19, however the medication was not delivered. On 5/13/19 the resident started to become agitated. On 5/14/19 the Administrator explained to the case manager if the medication was not at the facility, 911 would need to be called. The medication was delivered on 5/15/19 and verified the resident was not administered Clozarile from 5/8/19 till the night of 5/15/19. Resident			

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	#2 Resident #2 was admitted on 11/30/18 with a diagnosis including hypertension and depression. A physician order dated 7/25/18, documented the resident was prescribed aspirin 81 mg take daily. The May MAR documented the resident was not administered aspirin on 5/21/19, 5/22/19, 5/23/19 and 5/24/19. The resident's file lacked documented evidence of a physician order to hold aspirin for 5/21/19 through 5/24/19. On 5/30/19 at 11:00 AM, the resident verified aspirin was not administered on 5/21/19 through 5/24/19 because the pain physician explained aspirin must be held in order for the resident to receive a pain injection. On 5/30/19 at 11:20 AM, the Administrator explained the physician's office called the facility and instructed the facility to hold the administration of aspirin for 5/21/19 through 5/24/19. The Administrator verified the facility did not receive a written order to hold aspirin and verified the resident was not administered aspirin from 5/21/19 through 5/24/19. Severity: 2 Scope: 2 Complaint #NV57166			