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
	4582	A. BUILDING _____ B. WING _____	09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY CHILD RESIDENTIAL CARE 4	5825 TAPPAN DRIVE, RENO, NEVADA ,89523

(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 a State Licensure annual grading survey conducted in your facility on 09/12/18. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for five Residential Facility for Group beds for elderly and disabled persons and/or mental illness, and provides assisted living services. The census at the time of the survey was 5. Five resident files were reviewed, and three employee files were reviewed. The facility received a grade of B. 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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0080 SS= E	449.197 - Medical Services-By Medical Professional - NRS 449.197 Medical services may be provided only by medical professional. A member of the staff of a residential facility shall not provide medical services to a resident of the facility unless the member of the staff is a medical professional. Inspector Comments: Based on interview, record review and document review the facility failed to ensure blood glucose checks were performed by medical professionals for 1 of 2 sampled residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 09/08/18, with diagnoses including cardiovascular accident (CVA), chronic kidney disease, and diabetes mellitus. The clinical record revealed documentation of blood glucose levels on 09/09/18, 09/10/18, 09/11/18 and 09/12/18. On 09/12/18 at 12:30 PM, the Caregiver confirmed the blood glucose was measured by the Caregiver pricking Resident #4's finger and putting the blood on the Glucometer strip to measure the blood glucose. The Caregiver confirmed the left side of Resident #4 was paralyzed, had no feeling and the resident was unable to move the left arm. The Caregiver confirmed this was the procedure followed earlier this morning to obtain the blood glucose result. On 09/12/18 at 12:30 PM, the Administrator confirmed the Caregiver pricked the finger of Resident #4 to obtain blood for the Glucometer reading on the morning of 09/12/18. Severity: 2 Scope: 2	0080	1.) Resident is the one poking her finger with the assistance of a caregiver. Caregiver holds the left arm (bad arm), then resident has the needle pen on her right hand. 2.) Administrator and Operations manager will make sure that all caregivers are notified not to talk unless they know what they are saying. Also, we will make sure that future caregivers knows that we are not allowed to poke anymore in the facility. 3.) During admission process of the residents, we make sure that they are appropriate for our facility. In case there are insulin dependent or resident's that require blood glucose testing, we will make sure they can poke themselves or else they will not be admitted. 4.) The administrator, Nena Valera and operations manager, Alan Barcelon, are in charge of implementation. 5.) 9/12/18	09/12/2018

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0644 SS= C	NRS 449.184 - Posting of Administrator License and Rates - Operator of residential facility for groups: Posting of license and rates for services. A person who operates a residential facility for groups shall: 1. Post his or her license to operate the residential facility for groups; and 2. Post the rates for services provided by the residential facility for groups, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview the facility failed to post rates for services provided within public view. Findings include: On 09/12/18 at 9:30 AM, the rates for the services provided were not posted in a conspicuous place for viewing by the visitors and residents. On 09/12/18 at 2:45 PM, the Administrator confirmed the rates were not posted. The Administrator conveyed when the caregiver was cleaning the area, the picture frame with the posted rates was placed inside a cabinet in the kitchen, out of view. Severity: 1 Scope: 3	0644	1.) We have posted the Basic Rates in the wall instead of having it in the frame. 2.) By putting the rates in the wall, it will eliminate the potential of having it put away accidentally while cleaning. 3.) Now that the rates are posted in the wall, caregivers and the operations manager will be able to see to it that it will not be removed. 4.) The operations manager is responsible for the corrective action. 5.)9/12/18	09/12/2018
0870 SS= C	449.2742(1)(a-c) 2 - Medication Administration - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report; and (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). 2. Within 72 hours after the	0870	1.) Administrator signs and reviews the Medication Reviews for each resident every 6 months. 2.) Every time the doctor visits the facility (Geriatric Specialty Care), caregiver hands our MAR to the doctor to have them reviewed and signed. After that, caregiver will notify the administrator so that she can review and sign them. 3.) The administrator checks the MARs on a monthly basis to make sure that she does not forget to review and sign the MAR. 4.) Nena Valera, administrator. 5.) 9/12/18	09/12/2018

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	administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident ' s physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on observation, interview, and record review the facility failed to ensure the administrator initialed the six month medication review for 3 of 5 sampled residents (Resident #1, #2, and #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/14/16 with diagnoses including hypertension, chronic pain, and dementia with behaviors. The clinical record for Resident #1 documented on 04/03/18 and 10/17/17, the six month pharmacy reviews, however, the reviews lacked evidence of the initials of the Administrator. Resident #2 Resident #2 was admitted to the facility on 05/20/17 with diagnoses including hypertension, diabetes mellitus, and congestive heart failure. The clinical record for Resident #1 documented on 02/24/18 and 07/17/18, the six month pharmacy reviews, however, the reviews lacked evidence of the initials of the Administrator. Resident #3 Resident #3 was admitted to the facility on 03/01/12, with diagnosis including traumatic brain injury. The clinical record for Resident #1 documented on 02/23/18, 06/15/18, 07/14/17, and 10/31/17 six month pharmacy reviews, however, the reviews lacked evidence of the initials of the Administrator. On 09/12/18 at 3:00 PM, the Administrator confirmed the six month pharmacy reviews for Resident # 1, #2 and #3 were not initialed after received and reviewed. Severity: 1 Scope: 3			
0895 SS= E	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	0895	1.) We have furnished a copy of the medications of Resident#4 with the doctor's signature. 2.) We will make sure that we get the prescriptions or the medication lists with the doctor's signature, before admitting a resident. Also, we will make sure that it is signed by a doctor and not a pharmacist because we were under the impression that	09/18/2018

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	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, record review and document review the facility failed to ensure medications administered were documented by a physician's order for 2 of 5 sampled residents (Resident #2 and #4). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/20/17 with diagnoses including hypertension, diabetes mellitus, and congestive heart failure. The Medication Administration Record (MAR) for Resident #2 revealed the following medications for administration: -Lisinopril 20 milligrams (mg) one tablet by mouth daily, -Aspirin 81 mg one tablet by mouth daily, -Colpidogrel 75 mg one tablet by mouth daily -Furosemide 20 mg one tablet by mouth daily -Metoprolol 100 mg one tablet by mouth twice daily -Citalopram 40 mg one tablet by mouth daily -Potassium Chloride micro 20 milliequivalent (mEq) one tablet by mouth daily -Tamsulosin 0.4 mg one tablet by mouth daily, after breakfast -Advair disk 250/50 one puff every 12 hours -Atorvastin 20 mg one tablet by mouth daily at bedtime -Amitriptyine 25 mg one tablet by mouth daily at bedtime -Loperamide 2 mg one		we can have one from a pharmacist. 3.) We will be more stern on implementing this corrective actions. Due to circumstances of Resident#4, we were not able to furnish the medication lists with doctor's signature before her transfer. 4.) The operations manager will be make sure plan of correction is implemented. 5.) 9/18/18	

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	capsule four times a day as needed for diarrhea -Naphcon-A op two drops each eye daily, as needed for dryness The clinical record for Resident #2 lacked documentation of a physician's orders for the medications listed below: -Lisinopril 20 mg one tablet by mouth daily, -Aspirin 81 mg one tablet by mouth daily, -Colpidogrel 75 mg one tablet by mouth daily -Furosemide 20 mg one tablet by mouth daily -Metoprolol 100 mg one tablet by mouth twice daily -Citalopram 40 mg one tablet by mouth daily -Potassium Chloride micro 20 mEq one tablet by mouth daily -Tamsulosin 0.4 mg one tablet by mouth daily, after breakfast -Advair disk 250/50 one puff every 12 hours -Atorvastin 20 mg one tablet by mouth daily at bedtime -Amitriptyine 25 mg one tablet by mouth daily at bedtime -Loperamide 2 mg one capsule four times a day as needed for diarrhea -Naphcon-A op two drops each eye daily, as needed for dryness On 09/12/18 at 2:19 PM, the Administrator confirmed the lack of a physician's orders for the above listed medications for Resident #2. Resident #4 Resident #4 was admitted to the facility on 09/08/18, with diagnoses including cardiovascular accident (CVA), chronic kidney disease, and diabetes mellitus. The Medication Administration Record (MAR) for Resident #4 revealed the following medications for administration: -Glucosamine 1000 mg one tablet by mouth daily -Tradjenta 5 mg one tablet by mouth daily -Triamt/HCTZ 37.5-25 capsules, one capsule by mouth daily -Ezetimibe 10 mg one tablet by mouth daily -Losartan 25 mg one tablet by mouth daily -Amlodipine Besylate 5 mg one tablet by mouth daily -Zyrtec 10 mg one tablet by mouth twice daily -Mometasone 50 mg 2 spray each nostril for allergy -Antifungal 2% cream to rash as needed -Nystop 100,000 units powder twice daily to affected areas -Gilipizide 10 mg one tablet by mouth twice daily -Gabapentin 300 mg one capsule by mouth three times a day -Citalopram 10 mg one tablet by mouth daily -Atorovastin 40 mg one tablet by mouth daily -Polyethylene glucate one gram in eight ounces of water for constipation -Tussin DM syrup 10 milliliters by mouth as needed for cough -			

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	Gas-x 125 mg by mouth three times a day as needed for gas -MAPAP 500 mg one tablet by mouth every six hours as needed for pain The clinical record for Resident #4 lacked documentation of a physician's orders for the medications listed below: -Glucosamine 1000 mg one tablet by mouth daily -Tradjenta 5 mg one tablet by mouth daily -Triamt/HCTZ 37.5-25 capsules, one capsule by mouth daily -Ezetimibe 10 mg one tablet by mouth daily -Losartan 25 mg one tablet by mouth daily -Amlodipine Besylate 5 mg one tablet by mouth daily -Zyrtec 10 mg one tablet by mouth twice daily -Mometasone 50 mg 2 spray each nostril for allergy -Antifungal 2% cream to rash as needed -Nystop 100,000 units powder twice daily to affected areas -Gilipizide 10 mg one tablet by mouth twice daily -Gabapentin 300 mg one capsule by mouth three times a day -Citalopram 10 mg one tablet by mouth daily -Atorovastin 40 mg one tablet by mouth daily -Polyethylene glucate one gram in eight ounces of water for constipation -Tussin DM syrup 10 milliliters by mouth as needed for cough -Gas-x 125 mg by mouth three times a day as needed for gas -MAPAP 500 mg one tablet by mouth every six hours as needed for pain On 09/12/18 at 2:30 PM, the Administrator confirmed the lack of a physician's orders for the above listed medications for Resident #4. Severity: 2 Scope: 2			
0930 SS= E	449.2749(1)(a) - Resident File-Storage, Res Information - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he 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: (a) The full name, address, date of birth and social security number of the resident. Inspector Comments: Based on	0930	1.) Have filed the signed Medication Authorization to the resident's files. In light of confidentiality issues, operations manager and administrator have discussed not to use phones in transmission of personal information of our residents. We did not know that we can't use our phones. So starting 12/13/18, our facility will avoid using our phones to transmit personal data. 2.) We will make sure that during admission, all the necessary documents are in the resident's file. Moreover, we will make sure that all documents are printed out of a computer so we can avoid using our phones to trasnmit	09/12/2018

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	observation, interview and record review the facility failed to maintain resident confidentiality of resident records and ensuring a complete resident record was available in the facility without the need to present documents by photograph from a personal phone for 2 of 5 sampled residents (Resident #4 and #5). Findings include: Resident #4 Resident #4 was admitted to the facility on 09/08/18, with diagnoses including cardiovascular accident (CVA), chronic kidney disease, and diabetes mellitus. The clinical record for Resident #4 lacked documentation of the Ultimate User Agreement for the administration of medications by the facility. Resident #5 Resident #5 was admitted to the facility on 09/07/18, with diagnoses including cerebral palsy, asthma, diabetes mellitus, and morbid obesity. The clinical record for Resident #5 lacked documentation of the Ultimate User Agreement for the administration of medications by the facility. On 09/12/18 at 2:39 PM the Administrator confirmed the clinical records for Resident #4 and Resident #5 lacked documentation of the Ultimate User Agreement for the facility to administer medications. On 09/12/18 at 3:15 PM, the Administrator confirmed the missing Ultimate User Agreement documents for Resident #4 and #5. The Administrator contacted another member of the staff who then sent pictures of the Ultimate User Agreement for Resident #4 and #5 from a personal phone to the personal phone of the Administrator. On 09/12/18 at 3:20 PM the Administrator presented the pictures on the phone to confirm the Ultimate User Agreement had been signed for Resident #4 and Resident #5. Severity: 2 Scope: 2		personal information of our residents. 3.) The operations manager, during admission process, will check all necessary documents and file them appropriately. Then administrator will double check resident's file on a monthly basis. 4.) Nena Valera, administrator and Alan Barcelon, operations manager, will make sure plan of correction is implemented. 5.) 9/12/18. Confidentiality issues have been discussed and agreed on 12/13/18	