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 _____	**03/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRUCE OAK RESIDENTIAL CARE FACILITY	**4618 SPRUCE OAK DR, NORTH LAS VEGAS, NEVADA ,89031**

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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of an Annual State Licensure Survey and Complaint Investigation conducted at your facility on 03/07/19 and concluded on 03/22/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Groups beds for elderly and disabled persons and/or persons with mental illnesses, Category II residents. The census at the time of the survey was 3. Resident files for three active residents and one discharged resident were reviewed. Four employee files were reviewed. The facility received a grade of B. Complaint #NV00055943 with the allegation of physical abuse / injury of unknown origin could not be substantiated. The investigation of the allegation included: Interviews were conducted with the Administrator, the Hospice Nurse, the Lead Caregiver, one Caregiver, and one alert resident. Record review of four resident records, including the resident of concern. Records from the Hospice Agency were reviewed. 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		
0050 SS= G	449.194(1) - Administrator's Responsibilities-Oversight - NAC 449.194 Responsibilities of administrator. The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the	0050	1.) Facility meeting was conducted immediately to make sure all employees understand the importance of their function in Residents care. Instructed E2 to submit outside training in Hospice Care for more learning activities. 2.) During our meeting two in-service	04/26/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHERRY DAELTO Title: Administrator Date: 04/28/2019

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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	requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview and record review, the facility failed to ensure the Administrator maintained oversight and direction for staff members to provide care for a hospice resident with difficult and agitative behaviors (Resident #4). Findings include: Resident #4 (R4) R4 was admitted to the facility on 01/09/19 with diagnoses including diabetes mellitus, high blood pressure, and atrial fibrillation. R4 was assessed and admitted into the Hospice Program on 01/15/19 with diagnoses of atherosclerotic heart disease of native coronary artery and atrial fibrillation. R4 was pronounced deceased at the facility by the Hospice Nurse on 01/18/19 at approximately 1:40 AM. The facility failed to administer medications ordered for behaviors and pain (Xanax, Trazadone, Haldol, Quetiapine, Roxanol, and Ultram), as follows: Xanax: There were physician's admission orders dated 01/8/19 for Xanax, 0.25 mg, take 1 tablet every 12 hours PRN (as needed for) anxiety. There was no listing on the Medication Administration Record (MAR) for the Xanax. Trazadone: There were physician's admission orders dated 01/08/19 for Trazadone, 50 mg, 1 tablet at bedtime. There was no listing on the MAR for the Trazadone. There was no documented evidence the Trazadone was administered. Roxanol: There were physician's orders on the 01/15/19 Hospice Plan of Care for Roxanol, 20 mg / mL, give .25 mL every 2 hours PRN (as needed) for pain. There was no listing on the MAR for the Roxanol. Ultram: There were physician's orders on the 01/15/19 Hospice Plan of Care for Ultram, 50 mg, 1 tablet every 6 hours as needed for pain. There was no listing on the MAR for the Ultram. Quetiapine: There was a Physician's Order on the 01/16/19 Hospice Plan of Care Addendum for Quetiapine, 25 mg tablet, give 1 tablet by		training were scheduled as follows: 3/30/19 Understanding Caregivers Essential Functions and 4/6/19 End of Life Care. Per E1 request E2 submitted as follows: Patient Rights for Home Health and Hospice; Pain Management; Hospice Management;Grief, Mourning & Bereavement; Ethics in Death & Dying; Death & Dying 3.) This way they’re able to learned by filling out the end of life quiz & also get them a chance to asked and discussed.This facility will ensure that all employees will be guided accordingly as to their essential function and be able to understand there role in the end of life care. 4.) Administrator will monitor.	

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	mouth daily at bedtime (behaviors). There was no listing of the Quetiapine on the MAR's. There was no documented evidence the Quetiapine was administered. Haldol: There was a physician's order listed on the 01/15/19 Hospice Plan of Care for Haldol, 0.5 mg, give 1 tablet by mouth twice a day (behaviors). The Physician's Orders / Plan of Care Addendum dated 01/16/19 indicated, Discontinue Haldol 0.5 mg tablet BID. Give Haldol 2 mg/mL by mouth 3 times a day for behaviors. The MAR documented the Haldol was administered 2 times on 01/15/19, 0 (zero) times on 01/16/19, and 1 time on 01/17/19. On 03/07/19 at 4:00 PM, R3 (R4's roommate), who was alert and oriented, indicated R4 was pretty much quiet for the first couple of days, but then "Hollered out non-stop, thrashed around and fell on the floor. Maybe he was in pain, I don't know. At night R4 hit (E3 - the Lead Caregiver) in the shoulder and was swinging out wildly." On 03/07/19 at 1:00 PM, the Lead Caregiver indicated R4 began a behavior of moaning, screaming, yelling, and shouting out approximately three days after admission (from 01/12/19 through the date of death). R4 would continue this behavior regularly and continuously from 1:00 PM through 6:00 AM. R4 was not sleeping well, was not verbally responsive, demonstrated combative behaviors by swinging out at caregivers, especially the Lead Caregiver, and was not consolable. The Lead Caregiver indicated he was "having fits and screaming". On 03/07/19 at 2:30 PM, the Lead Caregiver verified the physician's orders for Xanax, Haldol, Trazadone, and Quetiapine were indicated for behaviors. The Lead Caregiver verified the MAR's documented Haldol was not administered per physician's orders. The Lead Caregiver verified the Xanax, Trazadone, and Quetiapine were not administered at all to R4. On 03/07/19 at 3:00 PM, the Lead Caregiver indicated she did not think R4 was in pain. The Lead Caregiver showed the Inspector a video			

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	recording of R4 in which R4 was moaning loudly and the Lead Caregiver was directly shouting at R4 to stop yelling, "You're not in pain! What's the matter with you? You're not in pain!" On 03/07/19 at 2:30 PM, the Lead Caregiver verified the Roxanol and the Ultram were not attempted to be administered for pain relief. The Lead Caregiver verified the physician's orders for the Roxanol and Ultram were ordered as needed for pain. The Lead Caregiver verified the Roxanol and the Ultram were not listed on the MAR's. On 03/21/19 at 4:45 PM, the Hospice Nurse indicated during a telephone interview that she saw R4 two times, and was made aware by the staff that R4 was moaning a lot. The Hospice Nurse indicated R4 was probably suffering from an end-of-life condition called "terminal restlessness", in which the resident has agitation, and visual / auditory hallucinations / delusions. The Hospice Nurse indicated the order for Haldol was changed to a regular basis 3 times a day as the Lead Caregiver did not seem to be administering the Haldol enough. The Hospice Nurse verified the Quetiapine should have been administered nightly as ordered, and may have helped with behaviors. On 03/07/19 at 4:00 PM, the Lead Caregiver indicated she had taken medication management training, which included training on as-needed medications and following physician's orders. The Lead Caregiver indicated a resident yelling out and moaning were indicators of both pain and agitation. The Lead Caregiver indicated she did not ask the Administrator for guidance in dealing with this resident's difficult behaviors. On 03/22/19 at 11:00 AM, the Administrator indicated during a telephone interview that she was aware R4 was admitted to the facility, was not made aware of the resident's behaviors until after the resident was deceased, and did not see R4. The Administrator indicated the behaviors were not communicated to her, and the Caregivers did not ask for			

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	guidance. The Administrator indicated she had taken a lot of caregivers' training courses, and if she had been consulted, she would have involved the physician and the Hospice nurse directly to conduct a thorough pain assessment and a medication assessment. The Administrator further indicated she thought the Lead Caregiver was lacking training in dealing with difficult residents. The Administrator indicated she did not have a system in place to monitor that medications were administered per physician's orders. Severity: 3 Scope: 1			
0103 SS= E	449.200(1)(d) - Personnel File - NAC 441A / Tuberculosis - NAC 449.200 Staffing requirements; limitations on number of residents; written schedule required for each shift. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. Inspector Comments: Based on interview and employee record review, the facility failed to ensure tuberculin testing was completed for 2 of 4 employees (Employee #1, #3). Findings include: Employee #1 (E1) E1 was employed at the facility as a Lead Caregiver on 07/01/17. There was no documented evidence of initial 2-step and annual tuberculin testing results for E1. (The only documented tuberculin testing results was a 1-step Mantoux tuberculin skin test administered on 05/26/17 and read on 05/29/17, 0 millimeter (mm) results.) Employee #3 (E3) E3 was employed at the facility as a Caregiver on 11/01/17. There was no documented evidence of annual 1-step tuberculin testing results for E3. On 03/07/19 at 3:00 PM, the Lead Caregiver verified the tuberculin testing was not complete for E1 and E3. Severity: 2 Scope: 2	0103	1. E1 hire date (11/17/17); E2 (hire date 07/01/17) submitted TB test for 2017 and most current 2019; E3 & E4 both hire 11/1/2017 both submitted TB test for 2019. 2. This facility must review employees TB test record for its veracity that it must be annually done before its due date. 3. Facility will make sure all employee's file will stay current. 4. Administrator will monitor.	04/27/2019
0878	NAC 449.2742(5)(6) - Medication / OTCs,	0878		04/06/201

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SS= D	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 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		1. Facility immediately conducted a meeting to review all residents current Medication /administration Review Sheet (MARS). Provided instruction on as needed medication such Anxiety & Pain medication, its uses and the manner to administer such medication. 2. Facility must at all times review medication changes, be written at MARS exactly as it is in the physician order. Also at all times be provided to the resident exactly the same as it is written in the physicians order and to be mindful if patient having anxiety or pain. 3. This facility will make sure the veracity of the medication order & be written at the MARS correctly. 4. Administrator will monitor.	9

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	ensure medications were administered as prescribed by the physician for one resident (Resident #4). Findings include: Resident #4 (R4) R4 was admitted to the facility on 01/09/19 with diagnoses including diabetes mellitus, high blood pressure, and atrial fibrillation. R4 was assessed and admitted into the Hospice Program on 01/15/19 with diagnoses of atherosclerotic heart disease of native coronary artery and atrial fibrillation. R4 was pronounced deceased at the facility by the Hospice Nurse on 01/18/19 at approximately 1:40 AM. The facility failed to administer medications ordered for behaviors and pain (Xanax, Trazadone, Haldol, Quetiapine, Roxanol, and Ultram), as follows: Xanax: There were physician's admission orders dated 01/08/19 for Xanax, 0.25 mg, take 1 tablet every 12 hours PRN (as needed for) anxiety. There was no listing on the Medication Administration Record (MAR) for the Xanax. Trazadone: There were physician's admission orders dated 01/08/19 for Trazadone, 50 mg, 1 tablet at bedtime. There was no listing on the MAR for the Trazadone. There was no documented evidence the Trazadone was administered. Roxanol: There were physician's orders on the 01/15/19 Hospice Plan of Care for Roxanol, 20 mg / mL, give .25 mL every 2 hours PRN (as needed) for pain. There was no listing on the MAR for the Roxanol. Ultram: There were physician's orders on the 01/15/19 Hospice Plan of Care for Ultram, 50 mg, 1 tablet every 6 hours as needed for pain. There was no listing on the MAR for the Ultram. Quetiapine: There was a Physician's Order on the 01/16/19 Hospice Plan of Care Addendum for Quetiapine, 25 mg tablet, give 1 tablet by mouth daily at bedtime (behaviors). There was no listing of the Quetiapine on the MAR's. There was no documented evidence the Quetiapine was administered. Haldol: There was a physician's order on the 01/15/19 Hospice Plan of Care for Haldol, 0.5 mg, give 1			

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	tablet by mouth twice a day (behaviors). The Physician's Orders / Plan of Care Addendum dated 01/16/19 indicated, Discontinue Haldol 0.5 mg tablet BID. Give Haldol 2 mg/mL by mouth 3 times a day for behaviors. The MAR documented the Haldol was administered 2 times on 01/15/19, 0 (zero) times on 01/16/19, and 1 time on 01/17/19. On 03/07/19 at 4:00 PM, R3 (R4's roommate), who was alert and oriented, indicated R4 was pretty much quiet for the first couple of days, but then "Hollered out non-stop, thrashed around and fell on the floor. Maybe he was in pain, I don't know. At night R4 hit (E3 - the Lead Caregiver) in the shoulder and was swinging out wildly." On 03/07/19 at 1:00 PM, the Lead Caregiver indicated R4 began a behavior of moaning, screaming, yelling, and shouting out approximately three days after admission (from 01/12/19 through the date of death). R4 would continue this behavior regularly and continuously from 1:00 PM through 6:00 AM. R4 was not sleeping well, was not verbally responsive, demonstrated combative behaviors by swinging out at caregivers, especially the Lead Caregiver, and was not consolable. The Lead Caregiver indicated he was "having fits and screaming". On 03/07/19 at 2:30 PM, the Lead Caregiver verified the physician's orders for Xanax, Haldol, Trazadone, and Quetiapine were indicated for behaviors. The Lead Caregiver verified the MAR's documented Haldol was not administered per physician's orders. The Lead Caregiver verified the Xanax, Trazadone, and Quetiapine were not administered at all to R4. On 03/07/19 at 3:00 PM, the Lead Caregiver indicated she did not think R4 was in pain. The Lead Caregiver showed the Inspector a video recording of R4 in which R4 was moaning loudly and the Lead Caregiver was directly shouting at R4 to stop yelling, "You're not in pain! What's the matter with you? You're not in pain!" On 03/07/19 at 2:30 PM, the Lead Caregiver verified the Roxanol and			

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	the Ultram were not attempted to be administered for pain relief. The Lead Caregiver verified the physician's orders for the Roxanol and Ultram were ordered as needed for pain. The Lead Caregiver verified the Roxanol and the Ultram were not listed on the MAR's. On 03/21/19 at 4:45 PM, the Hospice Nurse indicated during a telephone interview that she saw R4 two times, and was made aware by the staff that R4 was moaning a lot. The Hospice Nurse indicated R4 was probably suffering from an end-of-life condition called "terminal restlessness", in which the resident has agitation, and visual / auditory hallucinations / delusions. The Hospice Nurse indicated the order for Haldol was changed to a regular basis 3 times a day as the Lead Caregiver did not seem to be administering the Haldol enough. The Hospice Nurse verified the Quetiapine should have been administered nightly as ordered, and may have helped with behaviors. On 03/07/19 at 4:00 PM, the Lead Caregiver indicated she had taken medication management training, which included training on as-needed medications and following physician's orders. The Lead Caregiver indicated a resident yelling out and moaning were indicators of both pain and agitation. On 03/22/19 at 11:00 AM, the Administrator indicated during a telephone interview that she was not made aware R4 was moaning and screaming out until after the resident was deceased, did not review R4's medication records, and she did not have a system in place to monitor that medications were administered per physician's orders. Severity: 2 Scope: 1			

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0936 SS= E	449.2749(1)(e) - Resident file-NRS 441A Tuberculosis - 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure tuberculin testing was completed for 2 of 4 residents (Resident #1, #4). Findings include: Resident #1 (R1) R1 was admitted to the facility on 09/01/17 with diagnoses including major depressive disorder, anemia, and insomnia. There was no documented evidence of initial 2-step and annual 1-step tuberculin testing results for R1. The only documented tuberculin testing results were as follows: -1-step Mantoux tuberculin skin test, administered on 05/21/18 and read on 05/25/18, 0 millimeter (mm) results; and -2nd step Mantoux tuberculin skin test, administered on 06/04/18, with no documented results. Resident #4 (R4) R4 was admitted to the facility on 01/09/19 with diagnoses including hypertension, atherosclerotic heart disease, and protein calorie malnutrition. There was no documented evidence of tuberculin testing for R4. On 03/07/19 at 3:00 PM, the Lead Caregiver verified there were no 2-step tuberculin testing results available for R1 and R4. Severity: 2 Scope: 2 Repeat Deficiency: 05/03/18	0936	1. immediately audited all Residents Chart to make sure all residents file is current. 2. A written reminder with highlight in our monthly calendar was placed. This will provide all employee not to admit a patient without 2-step tuberculin testing. 3. Facility will ensure to check monthly calendar & update Residents Chart Audit for compliance & avoid delay in all residents Tuberculin testing. 4. Administrator and manager will monitor.	04/06/2019