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
	7942	A. BUILDING _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSARIO'S GROUP HOME	2885 RED ROCK STREET, LAS VEGAS, NEVADA ,89146

(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 survey conducted in your facility on 03/07/18. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for eight Residential Facility for Group beds which provide assisted living services for elderly and disabled persons, Category I & II residents. The census at the time of the survey was five. Five resident files were reviewed and three 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 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		
0870 SS= F	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	0870	For resident #1, the medication review would not be late anymore, it would be done every 6 months as the way its supposed to be. It would be schedule in the calendar 15 days before the due day. It would be monitor by the caregiver on regular basis. The administrator is responsible for making sure that all medications MAR would review every 6 months. On march 20, 18 the action was corrected it by making a calendar with the next medication review for each resident. Caregivers and administrator would be working together to be sure the medication review would be done in according manner. For resident #2, the medication review would not be late anymore, it would be done every 6 months as the way its supposed to be. It would be schedule in the calendar 15 days before the due day. It would be monitor by the caregiver on regular basis.	03/21/2018

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	response to a report submitted pursuant to paragraph (a). 2. Within 72 hours after the 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 record review and interview, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 5 of 5 residents residing in the facility for longer than six months and/or was initialed by the Administrator (Resident #1, #2, #3, #4 and #5). Findings include: Resident #1 Resident #1 was admitted on 05/08/17. On 03/07/18 in the afternoon, the resident file revealed a 02/06/18 medication review. The medication review was three mounts late. Resident #2 Resident #2 was admitted on 03/12/17. On 03/07/18 in the afternoon, the resident file revealed a 02/06/18 medication review. The medication review was five months late. Resident #3 Resident #3 was admitted on 04/16/16. On 03/07/18 in the afternoon, the resident file revealed a 02/06/18 medication review. The medication reviews was four months late. Resident #4 Resident #4 was admitted on 06/29/17. On 03/07/18 in the afternoon, the resident file revealed a 02/06/18 medication review. The medication reviews was more then a month late. Resident #5 Resident #5 was admitted on 06/12/17. On 03/07/18 in the afternoon, the resident file revealed a 02/20/18 and 02/23/18 medication review. The medication review was more then a month late. On 11/13/17 in the afternoon, the Administrator acknowledged the late medication reviews. Severity: 2 Scope: 3		The administrator is responsible for making sure that all medications MAR would review every 6 months. On march 20, 18 the action was corrected it by making a calendar with the next medication review for each resident. Caregivers and administrator would be working together to be sure the medication review would be done in according manner. For resident #3, the medication review would not be late anymore, it would be done every 6 months as the way its supposed to be. It would be schedule in the calendar 15 days before the due day. It would be monitor by the caregiver on regular basis. The administrator is responsible for making sure that all medications MAR would review every 6 months. On march 20, 18 the action was corrected it by making a calendar with the next medication review for each resident. Caregivers and administrator would be working together to be sure the medication review would be done in according manner. For resident #4, the medication review would not be late anymore, it would be done every 6 months as the way its supposed to be. It would be schedule in the calendar 15 days before the due day. It would be monitor by the caregiver on regular basis. The administrator is responsible for making sure that all medications MAR would review every 6 months. On march 20, 18 the action was corrected it by making a calendar with the next medication review for each resident. Caregivers and administrator would be working together to be sure the medication review would be done in according manner. For resident #5, the medication review would not be late anymore, it would be done every 6 months as the way its supposed to be. It would be schedule in the calendar 15 days before the due day. It would be monitor by the caregiver on	

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			regular basis. The administrator is responsible for making sure that all medications MAR would review every 6 months. On march 20, 18 the action was corrected it by making a calendar with the next medication review for each resident. Caregivers and administrator would be working together to be sure the medication review would be done in according manner.	
0920 SS= F	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 and interview, the facility failed to ensure medications were stored and secured in a locked area. Findings include: On 03/07/18 in the morning, the following was observed: Resident #3's bedroom - Two prescription creams zinc oxide 20% and Venelex Oin in a box under the resient's television. On 03/07/18 in the morning, Employee #1 acknowledged the medication was unsecured and reported that the nurse had used it. Severity: 2 Scope: 3	0920	On 03/07/18, the 2 prescriptions cream oxide 20% and Venelex Oin that were left in the resident's #3room by the nurse were put it back in the medication cabinet. The caregivers would be sure to tell the nurses to give the medicines back to them after they use them. The caregivers would monitor that any medications would not be left in any of the resident's rooms. The administrator is responsible for making sure that all the medicines would be store in the medication cabinet. The correction action was immediately done on march 7,18 by removing the 2 prescriptions creams zinc oxide 20% and Venelex Oin from resident #3 and put them in a secure place.	03/21/2018