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 _____	**10/23/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER'S TOUCH SENIOR HOME	**8918 KING JOHN COURT, LAS VEGAS, NEVADA ,89149**

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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 9/16/19 and finalized on 10/23/19. This complaint investigation was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facilities for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Sample size = 6 residents (one discharged). Complaint #NV00058209 with four allegations, was substantiated. Based on summary of severity and scope of deficient practices, the facility has been assigned a C grade. Allegation #1, residents were not turned or repositioned in a timely manner was substantiated. (See TAG Y826) Allegation #2, the facility did not have assigned staff for the night shift was substantiated. (See TAG Y992) Allegation #3, infection control practices were not followed could not be substantiated. Allegation #4, the facility did not have qualified staff was substantiated. (See TAG Y074, Y102, Y104, Y450 and Y1035) The investigation into the allegation regarding infection control practices included: Observation of provision of care by caregivers, utilizing infection control practices. Interviews with two residents, three caregivers and the Administrator/Owner. Review of resident records, including the resident of concern. 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 deficiencies unrelated to the complaint were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ROSALIE KOWATCH Title: ADMINISTRATOR Date: 12/02/2019

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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0074 SS= F	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for	0074	Employees 1 & 4 are no longer with the Facility as of 10/23/2019. Employee #3 received and completed the required elder abuse training on 11/11/2019. All other current employees will receive the required elder abuse training by 11/22/2019 if needed. All future employees will receive the required training prior to working with residents going forward. Administrator or designated employee will ensure this is happening going forward and will be reviewed upon each new hire.	11/22/2019

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	skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in			

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	violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 3 of 4 caregivers received initial elder abuse training prior to interacting with residents (Employee #1, #3 and #4). Findings include: Employee #1 (E1) E1 had a 9/15/19 start date. The employee file lacked documented evidence of initial elder abuse training. E1 was on duty, providing care to residents on 9/15/19 and 9/16/19. Employee #3 (E3) E3 had a 6/15/19 start date. The employee file lacked documented evidence of initial elder abuse training. E3 had been on duty, providing care to residents a minimum of five days a week since hire. Employee #4 (E4) E4 was considered a volunteer by the facility. E4 was on duty, providing care to residents between 8/17/19 and 9/12/19, including during the night shift when on duty alone. There was no file for E4 and no evidence of elder abuse training. Review of the facility Staffing Schedule for August 2019, documented E4 was paid for five days and seven nights of work between 8/16/19 and 8/31/19. On 9/16/19 in the afternoon, E4 confirmed they had worked several night shifts alone. On 9/16/19 in the afternoon, the Administrator confirmed the missing documentation and could not explain why E4 was on the schedule. Severity: 2 Scope: 3 Complaint #NV00058209			

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0102 SS= F	Personnel File - TB Screening - NAC 449.200 Personnel files. 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 record review, document review and interview, the facility failed to ensure 4 of 4 employees had pre-employment physical examinations and/or tuberculin (TB) tests at the time of hire (Employee #1, #2, #3 and #4). Findings include: Employee #1 (E1) E1 had a 9/15/19 start date. The employee file lacked documented evidence of a pre-employment physical examination or two-step TB test. On 9/16/19 at 2:02 PM, E1 and the Administrator explained all of E1's employment documents were in another state. Employee #2 (E2) E2 had a 8/10/19 start date. The employee file documented a one-step TB test result on 4/15/19 and a negative result and a second one-step TB test result on 4/24/19 and a negative result. The employee file lacked documented evidence of the first and second step inject dates. Employee #3 (E3) E3 had a 6/15/19 start date. The employee file lacked documented evidence of a pre-employment physical examination. Employee #4 (E4) E4 was considered a volunteer by the facility. E4 was on duty, providing care to residents between 8/17/19 and 9/12/19, including during the night shift when on duty alone. There was no file for E4 and no evidence of a pre-employment physical examination or two-step TB test. On 9/16/19 in the afternoon, the Administrator confirmed the missing documentation. Severity: 2 Scope: 3 Complaint #NV00058209	0102	Employees #1 & 4 were terminated on 10/23/2019. Employees #2 & 3 will receive new employee physicals and TB tests by 11/22/2019. Administrator or Designee will monitor for compliance with this going forward on all new hires. ALL EMPLOYEES UNDER THE MANAGEMENT COMPANY OPERATING THE FACILITY HAS BEEN TERMINATED EFFECTIVE THE AFTERNOON OF 11/17/19. ALL EMPLOYEE FILES WERE MISSING UPON THE OWNER TAKING OVER OTHER THAN THE OWNER AND THE RFA BINDERS IN THE LOCKED CABINET. I AM UNABLE TO PROVIDE EMPLOYEE #2 & #3'S PHYSICALS OR TB TESTS AS I HAVE NO FILE AT ALL TO REFER TO. UNDER THE OWNER'S MANAGEMENT, ALL NEW HIRES WILL HAVE THEIR PHYSICAL & TB TESTS AS REQUIRED PRIOR TO START DATE. AFTER HIRE, THEIR EXPIRATION WILL BE MONITORED IN ADVANCE TO ENSURE TIMELY CONTINUITY OF CURRENT DOCUMENTS EACH YEAR. ADMINISTRATOR OR DESIGNATED STAFF WILL REQUIRE ALL THE REQUIRED DOCUMENTS PRIOR TO HIRE, THEN MONITOR TO ENSURE NONE OF THE DOCUMENTS LAPSE EACH YEAR.	11/22/2019
0104 SS= F	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file	0104	Employee #4 was terminated on 10/23/2019. Employees #2 & 3 will be sent for new fingerprinting through NABS and will have their clearance letters placed in	11/22/2019

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	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 3 of 4 employees had evidence of completed background checks (Employee #2, #3 and #4). Findings include: Employee #2 (E2) E2 had a 8/10/19 start date. The employee file documented fingerprinting on 4/11/19. The employee file lacked documented evidence of a Nevada Automated Background Check System (NABS) Clearance Letter. Employee #3 (E3) E3 had a 6/15/19 start date. The employee file documented fingerprinting on 5/16/19. The employee file lacked documented evidence of a NABS Clearance Letter. Employee #4 (E4) E4 was considered a volunteer by the facility. E4 was on duty, providing care to residents between 8/17/19 and 9/12/19, including during the night shift when on duty alone. There was no file for E4 and no evidence of fingerprinting, a State and FBI background check or NABS Clearance Letter. Review of the facility Staffing Schedule for August 2019, documented E4 was paid for five days and seven nights of work between 8/16/19 and 8/31/19. On 9/16/19 in the afternoon, E4 confirmed they had worked several night shifts alone. On 9/16/19 in the afternoon, the Administrator confirmed the deficiencies and indicated they had had difficulty working in NABS. Severity: 2 Scope: 3 Complaint #NV00058209		their employee files for state review to ensure compliance. All new employees going forward upon hire will be sent for fingerprinting according to state regulations and a clearance letter will be placed in their file for state review and every five years. Administrator or Designee will ensure compliance with this on an ongoing basis. ALL THE EMPLOYEES UNDER A MANAGEMENT COMPANY HAVE ALL BEEN TERMINATED ON THE AFTERNOON OF 11/17 AND LEFT THE PREMISES. THE FACILITY IS UNABLE TO PROVIDE THE CLEARANCE LETTERS AS ALL EMPLOYEE FILES WERE MISSING WHEN CHECKED AFTER TAKING OVER THE MANAGEMENT OF THE FACILITY BY THE OWNER. I DO NOT KNOW THEIR BIO DATA TO CHECK NABS TO GET THE CLEARANCE LETTER TO COMPLY WITH YOUR REQUESTS, NO SS#, NO DOB OR ANYTHING. MANAGEMENT COMPANY HAS NOT RESPONDED TO MY REQUEST ,HENCE, I HAVE NOTHING FROM WHERE TO GET THE INFORMATION YOU REQUEST. MOVING FORWARD UNDER MY MANAGMENT, ALL EMPLOYEES OF THE FACILITY WILL HAVE THEIR CLEARANCE LETTER ON FILE. 2) NEW POTENTIAL HIRES WILL BE REQUIRED TO HAVE A CURRET CLEARANCE TO GET THE CLEARANCE LETTER, OR GET A NEW FINGERPRINT DONE IF OVER 6 MONTHS. 3) THE FACILITY WILL HAVE A CHECKLIST OF STAFF AND THE EXPIRATION DATES TO ENSURE CONTINUITY OF CURRENT DOCUMENTS. 7) NEW APPLICANTS WILL PROVIDE FACILITY WITH THEIR PERTINENT INFO FOR ADMINISTRATOR TO CHECK IF THEY HAVE BEEN CLEARED PREVIOUSLY BY NABS; IF NOT, NEW APPLICANT INFO WILL BE ENTERED	

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			AND THEY WILL BE REQUIRED TO GET THEIR FINGERPRINT DONE BY DUE DATE. THIS PROCESS WILL PREVENT DEFICIENT PRACTICE. THE ADMINISTRATOR OR DESIGNATED STAFF WILL ENSURE ALL NEW APPLICANTS EITHER HAVE A CURRENT CLEARANCE BY NABS OR THE APPLICANT NEEDS TO GET A NEW FINGERPRINT DONE. ONCE DONE AND CLEARED BY NABS, THEIR CLEARANCE LETTER WILL BE PUT INTO THEIR FILES.	

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0450 SS= F	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 2 of 4 employees had first aid and cardiopulmonary resuscitation (CPR) training within 30 days of hire (Employee #3 and #4). Findings include: Employee #3 (E3) E3 had a 6/15/19 start date. The employee file documented CPR training dated 7/2/18. The employee file lacked documented evidence of first aid training. Employee #4 (E4) E4 was considered a volunteer by the facility. E4 was on duty, providing care to residents between 8/17/19 and 9/12/19, including during the night shift when on duty alone. There was no file for E4 and no evidence of first aid or CPR training. Review of the facility Staffing Schedule for August 2019, documented E4 was paid for five days and seven nights of work between 8/16/19 and 8/31/19. On 9/16/19 at 2:20 PM, E4 confirmed they had worked several night shifts alone. On 9/16/19 in the afternoon, the Administrator confirmed the missing documentation. Severity: 2 Scope: 3 Complaint #NV00058209	0450	Employee #4 was terminated on 10/23/2019. Employee #3 will receive a new CPR/First aid training and prior to 11/22/2019 and a copy will be placed in employee file for state review. Administrator or Designated Employee will monitor on all new hires going forward to ensure compliance with this regulation. ALL EMPLOYEES UNDER THE MANAGEMENT COMPANY AT THE TIME, HAVE BEEN TERMINATED EFFECTIVE 11/17 . I AM UNABLE TO PROVIDE EMPLOYEE #3'S CPR/FIRST AID CARD AS HER ENTIRE FILE IS MISSING FROM THE FACILITY. I HAVE NO CONTACT WITH HER OR ANY OF THE FORMER EMPLOYEES OF THE MANAGEMENT COMPANY AT THE TIME. 2) UNDER THE MANAGEMENT OF THE OWNER, ALL NEW HIRES WILL BE REQUIRED TO PROVIDE THEIR CURRENT CPR/FIRST AID CARD UPON HIRE. THE ADMINISTRATOR OR DESIGNATED STAFF WILL MONITOR THE EXPIRATION DATE TO ENSURE CONTINUITY OF CURRENT STATE OF ALL EMPLOYEE'S FIRST AID/CPR. 7) WHEN A NEW APPLICANT IS INTERVIEWED AND PRESENTS ALL THEIR FILES, THE EXPIRATION DATES OF ALL THEIR DOCUMENTS WILL BE NOTED FOR CURRENT DATES. IF IT IS EXPIRED, THEY WILL BE REQUIRED TO GET A NEW VALID CARD AND IF NEEDED, THE ADMINISTRATOR WILL ASSIST IN FINDING AN INSTRUCTOR. THE NEW HIRE WILL HAVE THE CURRENT BEFORE START DATE. ADMINISTRATOR OR DESIGNATED STAFF WILL CHECK FOR CURRENCY OF ALL STAFF'S FIRST AID/CPR CARD GOING FORWARD.	11/22/2019
0826	Tracheostomy or Open Wound - NAC	0826	See attached care home policy on pressure	11/22/201

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SS= D	449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The records must include an explanation of the cause of the pressure or stasis ulcer. Inspector Comments: Based on record review, observation and interview, the facility failed to ensure 1 of 7 residents was turned every two hours to alleviate pressure sores (Resident #2); and failed to document turning of the residents. Findings include: Resident #2 (R2) R2 was admitted on 12/14/18 with diagnoses including Alzheimer's disease, seizure disorder and diabetes. The 7/30/19 Hospice Plan of Care/Comprehensive Assessment Update documented R2 was non-verbal and slept approximately 20 hours a day. On 9/16/19 in the morning and in the afternoon, the resident was observed in bed, sleeping. Attempts to interview R2 were unsuccessful. R2's record documented the resident was in the hospital between 7/9/19 and 7/16/19 for a high fever, cellulitis and sharp debridement of a right heel ulcer. The Plan of Care documented wounds on the left heel, right heel and coccyx. Interventions included wound care to all three areas twice weekly. The resident was noted as bedbound required. The Plan of Care documented a low air loss mattress was in place and staff were educated on turning and repositioning of the resident while in bed. The Plan of Care updates documented wound care visits on 7/29/19, 8/1/19 and 8/5/19, where staff assisted the nurse to position the resident for wound care. On 9/16/19 at 11:10 AM, the Administrator confirmed R2 was bedfast. On 9/16/19 at 10:30 AM, a former Caregiver on-site reported R2 had bed sores. The Caregiver		sores and bed turn log form. Bed turn log will be implemented on 11/16/2019 and staff will be trained on pressure sore care by 11/22/2019. Documentation of training completion will be placed in employee files. Administrator or Designee will monitor for compliance on ongoing basis daily and/or weekly. NEW EMPLOYEES HIRED FROM 11/17/19 HAVE ALL BEEN TRAINED ON TURNING/ REPOSITIONING/, ABOUT PRESSURE SORES, WAYS TO PREVENT SORES, AND THE PROCEDURE WHEN ONE DOES OCCUR. ANY BEDFAST RESIDENT WILL HAVE HIS/HER OWN BINDER IN THE BEDROOM WITH THE TURN/REPOSITIONING LOG. WHEN BEDFAST WAIVER SEEMS IMMINENT, A BEDFAST WAIVER REQUEST WILL BE MADE. RESIDENT #2, IS BEING REPOSITIONED THROUGHOUT THE DAY AND THE NIGHT, APPROXIMATELY EVERY 2 HOURS OR MORE OFTEN AS NEEDED. A LOG BOOK IS ON HIS BEDSIDE TABLE FOR OTHER VISITING PROFESSIONALS, RN, WOUND CARE RN, CNA, AND FACILITY STAFF TO NOTE. EACH TIME THE STAFF OR OTHER HOSPICE PERSONNEL ENTERS #2'S ROOM, HE IS TURNED AND REPOSITIONED. ADMINISTRATOR OR DESIGNATED STAFF WILL MAKE SURE ALL STAFF IS TRAINED ON PRESSURE SORE TOPIC AND INSTRUCTED TO MAKE SURE THEY TURN/RESPOSITION THE RESIDENT EVERY TWO HOURS AND INDICATE THIS REPOSITIONING ON THE LOG BINDER IN THE RESIDENT'S ROOM. ALL STAFF WILL BE GIVEN A TRAINING AS PART OF THEIR REQUIRED TRAINING HOURS.	9

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	explained R2 was changed four, sometimes six times a day, and was monitored. The resident had wound care. Pillows were placed on both sides of the resident every two hours. If there was an issue, the nurse was called. The Caregiver explained there was no charting of turning or repositioning the resident. The Plan of Care updated 8/1/19, documented a new stage II pressure ulcer to the left hip. A Hospice 8/23/19 progress note, documented two unstageable pressure ulcers to the left buttock and coccyx. A Hospice 8/26/19 progress note, documented the resident was receiving wound care for drainage on the right heel, and care for the left buttock and coccyx. On 9/16/19 in the morning, there was no documentation posted in R2's room of turning/repositioning. There was no documentation in R2's record of resident turning between Hospice wound care visits. On 9/16/19 at 11:40 AM, the Administrator reported R2 at one point was out of bed and could move around. The resident came to the facility with a pressure sore, and was under Hospice care. R2 could walk with a walker but the Hospice Nurse ordered R2 needed to stay in bed to prevent injury if sitting. As of 9/24/19 in the afternoon, the Administrator could not provide facility policies to address care for pressure sores and turning or repositioning of residents. Severity: 2 Scope: 1 Complaint #NV00058209			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		A. BUILDING _____ B. WING _____	**10/23/2019**

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0835 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 3. A written request submitted to the Division pursuant to this section must be received: (a) Before the administrator admits a resident; or (b) At the onset of a medical condition set forth in NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review and interview, the facility failed to obtain a bedfast waiver for 1 of 7 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 12/14/18 with diagnoses including Alzheimer's disease, seizure disorder and diabetes. On 9/16/19 in the morning and in the afternoon, R2 was observed in bed, sleeping. The 7/30/19 Hospice Plan of Care/Comprehensive Assessment documented R2 was non-ambulatory and bedbound required. The resident record lacked documented evidence of an approved bedfast waiver. On 9/16/19 at 11:10 AM, the Administrator confirmed R2 was unable to move without assistance and was bedfast. The Administrator verbalized there was no bedfast waiver request submitted to the Bureau for the resident. Severity: 2 Scope: 1	0835	Resident #2 received approved Bedfast waiver from HCQC on 10/15/2019. Approval letter is attached. Administrator or Designee will monitor to ensure that any resident in the future requiring a bedfast waiver have the appropriate request sent in and approved by the State per regulation going forward.	10/15/2019
0895 SS= A	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication 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	0895	Resident #1 is no longer a resident of the home as of 8/30/2019. All MARS going forward will be reviewed by Administrator or Designee on a routine basis to ensure accuracy and compliance with regulation. RESIDENT WAS ADMITTED AT NIGHT OF 7/24/19; MED TECH PREPARED MAR WHILE RFA WAS BUSY DOING ADMISSION WITH FAMILY FOR HOURS, AND FORGOT TO CHECK THE MAR AND THE PHYSICAL RX BUBBLE PACKS. RFA LEFT FOR OUT OF TOWN THE NEXT AM. OWNER OF MANAGEMENT COMPANY MET WITH FAMILY AND RESIDENT DAYS LATER AND REVIEWED ADMISSION PAPERWORK.	11/01/2019

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	prescription of the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for a 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 7/24/19, with diagnoses including hemiplegia and hemiparesis following a stroke, and muscle weakness. R1's 5/27/19 History and Physical, documented the resident had a Peg tube placement on 4/20/19. R1's 7/24/19 hospital Discharge Summary received on 10/23/19, documented the resident had a Peg Tube removed with the site healed. The resident's July 2019 and August 2019 MAR documented the following medication instructions (10): -Lisinopril 40 milligrams (mg) 1 tab via Peg tube daily -Carvedilol 25 mg 1 tab via Peg tube twice daily -Famotidine 20 mg 1 tab via Peg tube twice daily -Clonidine HCL 0.2 mg 1 tab via Peg tube every 8 hours -Hydralazine 100 mg 1 tab via Peg tube every 8 hours -Tramadol HCL 50 mg 1 tab via Peg tube every 6 hours as needed (listed via Peg tube on the MAR and PRN Medication Log) The remaining four medications were listed to administer by mouth. The medications were documented as administered daily by multiple caregivers. On 10/21/19 at 12:15 PM, the Administrator verbalized the resident was not on a Peg tube at the time of admission and was eating regular food. The Administrator explained the medications were listed on the MAR incorrectly, but could not explain why the MAR was written that way for the two months. The Administrator reported they checked the MARs once in awhile. This was a repeat deficiency from the 1/10/19 State Licensure survey and 3/28/19 required re-survey. Severity: 1 Scope: 1		ON 8/5/19, 911 WAS CALLED AND SHE TAKEN TO UMC FOR POSSIBLE C-DIFF. SHE RETURNED AT NIGHT ON 8/26/19. SHE MOVED TO ILLINOIS AT 9 AM IN THE TWO MONTHS, THE RESIDENT WAS AT THE FACILITY A TOTAL OF 15 DAYS. 2) MOVING FORWARD, RFA WILL CHECK THE BOTTLE/BUBBLE PACK WITH DISCHARGE ORDERS AND THE MAR FOR ACCURACY. ADMINISTRATOR OR THE DESIGNATED STAFF WILL VERIFY THE WORK OF THE MED TECH. ALL STAFF WILL BE TRAINED TO SPOT INCONSISTENCIES WITH THE MAR AND THE RX ON THE BOTTLE OR BUBBLE PACK PROMPTLY AND REPORT TO THE RFA FOR FURTHER CLARIFICATIONS. MY GUESS AS TO THE RX MENTIONING THE PEG TUBE IS A CLERICAL ERROR AT THE NURSING HOME WHERE REFILLS WERE AUTO UNTIL NEW ORDERS HAD TO BE WRITTEN. 7) ADMINISTRATOR OR DESIGNATED STAFF WILL FREQUENTLY CHECK THE MAR AND THE RESIDENT'S MEDS IN THE BIN TO ENSURE ALL IS WRITTEN AND DISPENSED CORRECTLY.	
0992 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s	0992	Additional staff is being hired to ensure compliance with regulation as of 11/22/2019. No employee will work a 24	11/22/2019

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	disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768. Inspector Comments: Based on document review and interview, the facility failed to ensure at least one member of the staff was on duty and awake during the night shift; and failed to ensure staff did not work 24 hour shifts. Findings include: On 9/16/19 in the afternoon, the facility August 2019 Staffing Schedule (handwritten) documented no assigned caregiver on duty for the night shift on the following dates: 8/3/19, 8/4/19, 8/16/19, 8/20/19, 8/23/19 and 8/26-8/31/19. On 9/16/19 in the afternoon, the facility August 2019 (handwritten) and September 2019 Staffing Schedules documented one caregiver working 24 hour shifts on the following dates: 8/17-8/19/19 (two caregivers), 8/21/19 (two caregivers), 8/22/19 (two caregivers), 8/25/19 (two caregivers), 9/1-9/3/19 and 9/15/19. The Plan of Correction from the 1/10/19 annual grading survey, documented the Administrator would fill in when caregivers were sick or absent. On 9/16/19 at 3:30 PM, the Administrator confirmed there was no staff assigned for the night shift on the dates noted above and acknowledged some of the days at least one caregiver worked 24 hours. The Administrator explained the facility was currently short staffed and there was difficulty hiring and maintaining qualified caregivers. This was a repeat deficiency		hour shift and the Administrator or Designee will cover any shift that would leave the facility with insufficient staffing for the overnight. WHEN THERE WAS A STAFF SICK, OFF, ON VACATION, OR SHORT, THE ADMINISTRATOR COVERED FOR THOSE SHIFT SHORTAGES, ESPECIALLY AT NIGHT. HOWEVER, ADMINISTRATOR IS HIRING EXTRA STAFF SO ONE CAN FILL IN IF ONE CANNOT MAKE IT TO WORK FOR WHATEVER REASON. THERE WILL ALWAYS BE A STAY-AWAKE NIGHT STAFF FROM 7PM TO 7AM DAILY. **NO ONE WHO WORKED A DAY SHIFT WILL COVER AT NIGHT THE SAME NIGHT; THEREFORE NO ONE WILL WORK 24 HOURS.** ADMINISTRATOR OR DESIGNATED EMPLOYEE WILL MAKE THE SCHEDULE SO NO ONE WORKS 24 HOURS. 2) ONLY WAY IS TO HIRE EXTRA STAFF THAT CAN COVER ANY ABSENCES. 3) STAFF WILL BE MONITORED AND IF ONE IS NOT EFFECTIVE, ANOTHER WILL BE SOUGHT PRIOR TO BEING LET GO. 7) ADMINISTRATOR OR DESIGNATED STAFF WILL KEEP LOOKING FOR BETTER STAFF FOR FUTURE HIRE.	

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	from the 1/10/19 State Licensure survey. Severity: 2 Scope: 3 Complaint #NV00058209			

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1035 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 1 of 4 caregivers received 2 hours of Alzheimer's training within 40 hours of employment (Employee #4). Findings include: Employee #4 (E4) E4 was considered a volunteer by the facility. E4 was on duty, providing care to residents between 8/17/19 and 9/12/19, including during the night shift when on duty alone. There was no file for E4 and no evidence of the required two hours of Alzheimer's training. Review of the facility Staffing Schedule for August 2019, documented E4 was paid for five days and seven nights of work between 8/16/19 and 8/31/19. On 9/16/19 in the afternoon, E4 confirmed they had worked several night shifts alone. On 9/16/19 at 2:30 PM, the Administrator acknowledged the missing documentation. Severity: 2 Scope: 1 Complaint #NV00058209	1035	Employee #4 was terminated on 10/23/2019. Administrator or Designee will ensure that all new hires will receive the required 2 hours of Dementia/Alzheimer's training within their first 40 hours of work or sooner going forward. Any existing employees missing the required training will have theirs completed by 11/22/2019. ALL EMPLOYEES OF MANAGEMENT COMPANY HAVE BEEN TERMINATED EFFECTIVE THE AFTERNOON OF 11/17. MOVING FORWARD, ALL NEW HIRES WILL HAVE THE FULL 10 HOURS ALZHEIMER/DEMENTIA TRAINING PRIOR TO HIRE OR 2 HRS. WITHIN 40 HOURS OF HIRE. 3) ADMINISTRATOR OR DESIGNATED STAFF WILL CHECK FOR ALL DOCUMENTS. A CALENDAR WITH THE EXPIRATION DATE OF WHICH TRAINING, PHYSICAL, OR TB TEST IS COMING UP IN SUCCESSION 7) ADMINISTRATOR OR DESIGNATED STAFF WILL MAKE SURE A NEW HIRE WIL HAVE THE TRANING SO THEY CAN BETTER CARE FOR THE RESIDENTS AND PROVIDE BETTER SERVICE.	11/22/2019