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
	8827	A. BUILDING _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH & HOPE HOME CARE, LLC	**973 LEPORI WAY, SPARKS, NEVADA ,89431-1165**

(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 change of ownership and change of name State Licensure survey conducted in your facility on 11/07/17. This State Licensure survey was conducted by authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The amended license will be mailed to you under separate cover. The facility is licensed for five Residential Facility for Group beds for elderly disabled persons, Category II residents. The census at the time of the survey was four. Four resident files were reviewed and five employee files 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 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8827	A. BUILDING _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH & HOPE HOME CARE, LLC	**973 LEPORI WAY, SPARKS, NEVADA ,89431-1165**

(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
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: NRS 449.184 Operator of residential facility for groups, facility for intermediate care or facility for skilled nursing to post certain information in conspicuous place. 1. A person who operates a residential facility for groups shall: (a) Post his or her license to operate the residential facility for groups; (b) Post the rates for services provided by the residential facility for groups; and (c) Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Based on observation and interview, the facility failed to post the designated representative of the owner or operator of the facility. Findings include: On 11/07/17 in the morning, the designated representative was not observed posted in the facility. On 11/07/17 in the morning, the Owner confirmed the findings and acknowledged the deficiency. Severity: 1 Scope: 3	0644	The designated employee was not done because the facilitywas licensed under Good Samaritan. The incoming administrator is licensed forFaith & Hope Home Care. After the survey, we had made the necessary changes tocomply with the regulation. The administrator assigned 2 designated employee incharge during his absence. The following documents will be posted on the wall.	11/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8827	A. BUILDING _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH & HOPE HOME CARE, LLC	**973 LEPORI WAY, SPARKS, NEVADA ,89431-1165**

(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
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 secure. Findings include: On 11/07/17 at 9:27 AM, observed the following unsecured medications: - The medication cabinet was unlocked with the caregivers not in sight. - The medication refrigerator was unlocked with Ensure and Latanoprost 0.005% eye drops. - Bismatrol Suspension was on the top of the desk in the living room. On 11/07/17, the Owner confirmed the findings and acknowledged the deficiency. Severity: 2 Scope: 3	0920	The incoming owner and administrator will work hard toreorganize the facility standards and procedures, this includes, training theemployee of correct ways to maintain and store medication of our residents. After the survey, the medication cabinets were locked andkeys were given to the caregiver. Everyone was given notice that medicationstorage should be locked at all times. The Bismatrol was discontinued and removedaccordingly. The refrigerated medication were properly stored in a lockedcontainer and was put inside the refrigerator. Employee #4 (Owner) will be in charge of keeping track ofthe medication storage being locked at all times. The administrator will bechecking storage during his visits.	11/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8827	A. BUILDING _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH & HOPE HOME CARE, LLC	**973 LEPORI WAY, SPARKS, NEVADA ,89431-1165**

(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
0923 SS= D	449.2748(3)(a-b) - Medication Container - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure over the counter medications were plainly labeled for 1 of 4 residents (Resident #2). Findings include: On 11/07/17 at 11:27 AM, a review of the resident's medications, Medication Administration Records (MAR) and physician orders revealed the following: Resident #2 Resident #2 was admitted on 01/07/15, with diagnoses including coronary artery disease, dyslipidemia, pacemaker and chronic heart failure. The resident was prescribed Thick-IT powder. The medication container lacked documented evidence of the physician's name. On 11/07/17 at 11:27 AM, the Owner confirmed the findings and acknowledged the deficiency. Severity: 2 Scope: 1	0923	The facility put the necessary label on the over the countersupplement to correct the deficiency. The caregivers were notified that OTCmedication and supplements should always have a label with Patient’s name andDoctor’s name at the minimum. Administrator and Employee #4 (Owner) will monitor that allof the medications are properly labeled. This will be done on a monthly basis.	11/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8827	A. BUILDING _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH & HOPE HOME CARE, LLC	973 LEPORI WAY, SPARKS, NEVADA ,89431-1165

(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
0936 SS= D	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 record review and interview, the facility failed to ensure 1 of 4 residents met the requirements concerning tuberculosis (TB) testing (Resident #1). Findings include: Resident #1 was admitted on 03/11/16, with diagnoses including hypertension, pneumonia, weakness and cognitive deficit. On 11/07/17 in the morning, a review of the resident's file revealed a second-step TB test with a read date of 03/05/16 and a negative result. The annual one-step TB test documented a read date of 06/10/17 and a negative result. The 2017 annual TB test was late. On 11/07/17 in the morning, the Owner confirmed the late test and acknowledged the deficiency. Severity: 2 Scope: 1	0936	Resident #1 had his 2 step TB skin test in the year of 2017 becauseit was over due from the year 2016. Unfortunately, the facility failed to filethe document in Resident #1’s records. We have furnished the necessary documents and put it on theresident’s file. Administrator and Employee #4 will monitor all of theresident’s and employee’s file to make sure that TB skin test and physical assessmentsare done on time.	11/08/2017