STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8983	A. BUILDING _____ B. WING _____	07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNNY ANGEL'S CARE HOME	4460 MARLENA CIRCLE, LAS VEGAS, NEVADA ,89129

(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 at your facility on 07/03/19. This State Licensure survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 10 Residential Facility 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. Seven resident files were reviewed and four 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		
0050 SS= E	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) 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 requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, interview, record review and document review, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision. Findings include: Please see TAGs Y556, Y850 and Y859. Severity: 2 Scope: 2	0050	Tag#0050 A)The Administrator will provide oversight by visiting weekly and monitor each resident for changes in behavior, physical condition and teach caregivers and owners how to properly execute an incident report. By contacting Family members Doctors and Administrator, as well as additional authorities depending upon the circumstances. B) The Administrator will call the group homes to learn of unusual activities to solve any foreseen problems. C) The Administrator is responsible for this action D) 08/09/2019	08/09/2019
0556 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or	0556	Tag#0556 A) The Administrator trained staff on how to properly fill out an incident report, be it physical, verbal or sexual abuse and how to report to the appropriate state entity. B) The Administrator is retraining staff on	08/09/2019

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	sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on interview, record review and document review, the facility failed to report a physical altercation involving 1 of 7 sampled residents (Resident #1) and sexual behavior involving 1 of 7 sampled residents (Resident #5) to the appropriate State entity. Findings include: Resident #1 (R1) R1 was admitted on 03/30/19, with diagnoses including dementia and depression. An Incident Report dated 04/23/19, documented R1 was sitting on the couch with another resident. R1 coughed and the other resident hit R1 on the left side of the face. R1 had bruises on the left side of the face. Facility documentation lacked documented evidence a report had been made to the appropriate State entity regarding the incident. Resident #5 (R5) R5 was admitted on 01/10/19, with diagnoses including hydrocephalus and depression. An Incident Report dated 06/12/19, documented R5 was walking naked around the room while R5's roommate was sitting in the living room. The Owner opened R5's door and R5 expressed "I need someone to suck my dick". Facility documentation lacked documented evidence a report had been made to the appropriate State entity regarding the incident. An Incident Report dated 06/15/19, documented R5 came out of the bedroom, stood in the doorway and started masturbating. A resident (R3) witnessed R5 and was scared and started to scream. Facility documentation lacked documented evidence a report had been made to the appropriate State entity regarding the incident. An Incident Report dated 06/16/19, documented R5 was being assisted with a shower by the Owner. When R5 was behind the shower curtain, R5 began to masturbate. Facility documentation lacked documented evidence a report had been made to the appropriate State entity regarding the incident. An Incident Report dated 06/27/19, documented R5 walked		elder abuse to further facilitate the importance. The Administrator is closely communicating with the staff to be advised of changes and unusual behavior, to respond accordingly to the need of the residents. The Admin is monitoring the Group home weekly. C) The Administrator is responsible D) 08/10/2019	

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	naked again when going to the bathroom to take a shower. The Owner attempted to stop R5 and R5 cursed and began masturbating again. R5 asked the Owner "you want to suck my dick?" A hospice progress note dated 06/27/19, documented the group home Owner notified hospice R5 was walking naked and was caught masturbating. Hospice advised the Owner to divert R5's attention and provide privacy. Facility documentation lacked documented evidence a report had been made to the appropriate State entity regarding the incident. On 07/03/19 in the afternoon, the Owner indicated suspicions of physical, verbal and sexual abuse were documented in an Incident Report. The Owner was unaware the facility was supposed to report the physical altercation between R1 and another resident and R5's sexual behavior toward a staff member and a resident to the appropriate State entity. The Owner acknowledged the physical altercation between R1 and another resident had not been reported to the appropriate State entity. The Owner acknowledged R5's sexual behavior directed at a staff member and a resident had not been reported to the appropriate State entity. Severity: 2 Scope: 1			

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, interview, record review and document review, the facility failed to ensure 1 of 7 sampled residents was free from restraints (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 06/27/19, with diagnoses including congestive heart failure and chronic obstructive pulmonary disorder. On 07/03/19 in the morning, R2 was observed lying in bed. The bed was pushed against the wall on the left side. Half side rails were in the up position on the right side of the bed. A mini cognitive assessment was attempted, however R2 was confused by the questions and the interview was stopped. R2's medical record documented R2 was receiving hospice services, was confused and dependent on staff for ADL's. On 07/03/19 in the morning, the Owner indicated R2 was dependent on staff for all activities of daily living (ADL's). The Owner indicated R2 was unable to move in the bed. The Owner indicated R2 had not used the half side rails on the right side of the bed for mobility. The Owner indicated the half side rails were in the up position to avoid R2 from falling out of the bed. The Owner indicated R2 had not fallen out of the bed since admission. The Owner acknowledged R2's bed should have been moved away from the wall and side rails should have been down. A statement of Residents' Personal Rights (undated) documented restraints both physical and chemical were prohibited. Severity: 2 Scope: 1	0620	Tag #0620 A)The residents bed has been removed from against the wall to place the quarter rail down. The staff was informed that, a bed can be against the wall at the residents request, but no half rail while bed is in such position. The owner and admin has completed an inspection to ensure this matter. B) Staff will cross check one another to ensure the deficiency does not reoccur. C) The Administrator will monitor this during a weekly visit. The admin will also monitor incoming residents to evaluate for bedfast or restraint concerns. D) The Administrator & the owner)08/09/2019	08/09/2019
0850 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical	0850	Tag#0850 A)The new Administrator is working with the Owner in regards to residents health and	08/01/2019

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	examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on interview and record review, the facility failed to notify the resident's family and the physician after 1 of 7 sampled residents (Resident #5) displayed a significant change in behavior. Findings include: Resident #5 (R5) R5 was admitted on 01/10/19, with diagnoses including hydrocephalus and depression. A History and Physical dated 10/17/18, documented R5 had a history of hydrocephalus and was confused. R5 had anxiety and depression at times. R5 was alert and oriented times two and was in no apparent distress. A hospice care plan dated 01/13/19, indicated R5 had seizures and depression. R5 was unable to provide personal care due to progression of neurological disorder. An Incident Report dated 06/12/19, documented R5 was walking naked around the room while R5's roommate was sitting in the living room. The Owner opened R5's door and R5 expressed "I need someone to suck my dick". The Incident Report documented the family was notified. The Incident Report lacked documented evidence the physician was notified. An Incident Report dated 06/15/19, documented R5 came out of the bedroom, stood in the doorway and started masturbating. A resident (R3) witnessed R5 and was scared and started to scream. The Incident Report documented the family was notified. The Incident Report lacked documented evidence the physician was notified. An Incident Report dated 06/16/19, documented R5 was being assisted with a shower by the Owner. When R5 was behind the shower curtain, R5 began to masturbate. The Incident Report lacked		whom to report. The owner also has been notified to contact administrator for guidance in the process, to ensure proper handling of situations. The facility has been trained whom to contact and when. The staff has been re-trained on elder abuse and how and when to notify the proper authorities. In the event the administrator is not at the facility during an illness, the staff is trained to contact the Administrator for all concerns or probable concerns. B) During weekly contacts by visitation and phone calls, the Administrator will ask and check for reports and proper reporting. C) The administrator and owner is responsible 08/09/2019	

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	documented evidence the family and the physician were notified. An Incident Report dated 06/27/19, documented R5 walked naked again when going to the bathroom to take a shower. The Owner attempted to stop R5 and R5 cursed and began masturbating again. R5 asked the Owner "you want to suck my dick?" The Incident Report documented the family was notified. A hospice progress note dated 06/27/19, documented the group home Owner notified hospice R5 was walking naked and was caught masturbating. Hospice advised the Owner to divert R5's attention and provide privacy. On 07/03/19 in the afternoon, the Owner indicated R5 had been admitted in January. Since R5's admission, the Owner had not observed R5 display sexual behaviors toward staff or residents. The Owner indicated R5 began displaying sexual behavior on 06/12/19. The Owner indicated the sexual behavior was new behavior and the Owner had not seen this type of behavior from R5 before. The Owner explained if a resident had a significant change in behavior, the facility was to complete an Incident Report and notify the family and physician immediately. The Owner indicated because R5 was receiving hospice services, the hospice nurse and physician were to be notified. The Owner acknowledged R5's medical record lacked documented evidence a hospice nurse and/or physician were notified regarding R5's change in behavior on 06/12/19 and 06/15/19. The Owner acknowledged R5's medical record lacked documented evidence R5's family and a hospice nurse and/or physician were notified regarding R5's change in behavior on 06/16/19. Severity: 2 Scope: 1			
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her	0859	Tag# 0859 Resident #5 Has an updated assessment by the Hospice Physician. All employees has been informed regarding Residents and the changes in behavior. The Administrator has eluded to the staff of notifying her on the event of behavioral changes and what to do, outside of normal assessments. B) The Administrator is determined to teach this new staff that we may have a great facility. The Admin will closely monitor the	08/02/2019

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	physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to assess 1 of 7 sampled residents (Resident #5) after the resident displayed a significant change in behavior. Findings include: Resident #5 (R5) R5 was admitted on 01/10/19, with diagnoses including hydrocephalus and depression. A History and Physical dated 10/17/18, documented R5 had a history of hydrocephalus and was confused. R5 had anxiety and depression at times. R5 was alert and oriented times two and was in no apparent distress. A hospice care plan dated 01/13/19 indicated R5 had seizures and depression. R5 was unable to provide personal care due to progression of neurological disorder. An Incident Report dated 06/12/19, documented R5 was walking naked around the room while R5's roommate was sitting in the living room. The Owner opened R5's door and R5 expressed "I need someone to suck my dick". R5's medical record lacked documented evidence an assessment of R5 had been completed after the incident occurred. An Incident Report dated 06/15/19, documented R5 came out of the bedroom, stood in the doorway and started masturbating. A resident (R3) witnessed R5 and was scared and started to scream. R5's medical record lacked documented evidence an assessment of R5 had been completed after the incident occurred. An Incident Report dated 06/16/19, documented R5 was being assisted with a shower by the Owner. When R5 was behind the shower curtain, R5 began to masturbate. R5's medical record lacked documented evidence an assessment of R5 had been completed after the incident occurred. An Incident Report dated 06/27/19, documented R5 walked naked again when going to the bathroom to take a shower. The Owner attempted to stop R5 and R5 cursed and began masturbating again. R5 asked the Owner "you want to suck my dick?" A hospice progress note dated 06/27/19, documented the group home Owner notified hospice R5 was		staff by way of phone calls and frequently (Unscheduled visits) to guide the staff in excellence. Thank you for your understanding in advance! C Responsibility is for the Administrator to carry-out! D)08/02/2019	

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	walking naked and was caught masturbating. Hospice advised the Owner to divert R5's attention and provide privacy. R5's medical record lacked documented evidence an assessment of R5 had been completed after the incident occurred and after the Owner notified the hospice nurse. On 07/03/19 in the afternoon, the Owner indicated R5 had been admitted in January. Since R5's admission, the Owner had not observed R5 display sexual behaviors toward staff or residents. The Owner indicated R5 began displaying sexual behavior on 06/12/19. The Owner indicated the sexual behavior was new behavior and the Owner had not seen this type of behavior from R5 before. The Owner indicated the sexual behavior had been increasing since 06/12/19. The Owner explained if a resident had a significant change in behavior, the facility was to complete an Incident Report and notify the family and physician immediately. The Owner indicated because R5 was receiving hospice services, the hospice nurse and physician were to be notified. The Owner was unaware an assessment of R5 should have been completed. The Owner acknowledged R5 had a significant change in behavior. The Owner indicated there had been no assessment of R5 completed. The Owner indicated there had not been a review of R5's medications. Severity: 2 Scope: 1			
0876 SS= F	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met.	0876	Tag#0878 All said Residents has a signed" Ultimate user agreement" and is located in documents. B) The Owner will contact the administrator upon the entrance of a new client into the facility, at the administrator's request. This will ensure the owner/mgr will have all requested documents signed. Once the owner becomes familiar with the process, over time, the Administrator will include incoming papers as a part of the monthly check! The Administrator will be responsible for handling this matter. D) 08/02/19	08/02/2019

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	Inspector Comments: Based on interview and record review, the facility failed to ensure an ultimate user agreement was completed and signed for 4 of 7 sampled residents (Resident #2, #3, #4 and #7). Findings include: Resident #2 (R2) R2 was admitted on 06/27/19, with diagnoses including congestive heart failure and chronic obstructive pulmonary disorder. R2's medical record lacked documented evidence an ultimate user agreement was completed and signed. Resident #3 (R3) R3 was admitted on 05/17/19, with diagnoses including dementia. R3's medical record lacked documented evidence an ultimate user agreement was completed and signed. Resident #4 (R4) R4 was admitted on 02/15/19, with diagnoses including dementia with behavioral disturbance. A Medication Management Agreement dated 02/15/19, lacked documented evidence R4 or R4's representative had signed for the facility to administer medications. Resident #7 (R7) R7 was admitted on 02/07/19, with diagnoses including debility/weakness and depression. R7's medical record lacked documented evidence an ultimate user agreement was completed and signed. Medication Administration Records (MAR's) dated July 2019, documented the facility administered R2, R3, R4 and R7's medications on a daily basis. On 07/03/19, the Owner indicated R2, R3, R4 and R7 required medication administration. The Owner indicated when a resident was admitted, a Medication Management Agreement was completed and signed which indicated the facility was authorized to administer medications. The Owner acknowledged R2, R3, R4 and R7 did not have a completed and signed ultimate user agreement. Severity: 2 Scope: 3			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver 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	0878	Tag# 0878 The Administrator has instructed all employees about receiving medicine without an order. Be it family, friend or nurse etc., it must accompany an order. Referred to medication class/es. B) We have acquired an order for this medication and it is now listed on the MAR. Before we receive and medication for a resident our first step is to request for an order.	08/01/2019

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	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 (Previously Y 0879) (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 observation, interview, record review and document review, the facility failed to ensure over-the-counter medication being administered to 1 of 7 sampled residents (Resident #7) had a physician's order. Findings include: Resident #7 (R7) R7 was admitted on 02/07/19, with diagnoses including debility/weakness and depression. On 07/03/19 in the morning, R7 expressed having left and right foot pain. R7 expressed frustration because R7 could not have Blue Emu oil in R7's bedroom. R7 indicated the Blue Emu oil was an over-the-counter medication and relieved foot pain. R7 indicated the Caregivers applied the Blue Emu oil to the feet twice a day or as		C) The Administrator an owner will seek to provide this for all involved. D)08/01/19 and continues	

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JOHNNY ANGEL'S CARE HOME	4460 MARLENA CIRCLE, LAS VEGAS, NEVADA ,89129

(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
	needed. On 07/03/19 in the afternoon, Blue Emu oil was observed in a locked drawer in the hallway. On 07/03/19 in the afternoon, the Owner indicated the facility used the Blue Emu oil on R7's feet a couple times throughout the day. The Owner indicated R7 used the Blue Emu oil on an as needed basis. R7's medical record lacked documented evidence of a physician's order for the Blue Emu oil being administered to R7 on an as needed basis. On 07/03/19 in the afternoon, the Owner indicated Blue Emu oil was an over-the-counter medication and required a physician's order. The Owner acknowledged R7 did not have a physician's order for the Blue Emu oil. A Resident's Admission Agreement (undated), documented the physician approved all over-the-counter medication in writing and verification and was kept in the confidential file. Severity: 2 Scope: 1			