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 _____	**06/12/2020**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of the Complaint Investigation survey and Annual Grading survey initiated at your facility on 05/28/20 and finalized on 06/12/20. This survey was conducted in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The census at the beginning of the survey was eight. Eight resident files and three closed resident records were reviewed. The facility received a grade of B. Three complaints were investigated: -Complaint #NV61126 with the following allegations was not substantiated: Allegation #1: Abuse from Caregiver to Resident: A male caregiver grabbed the resident by the shirt collar and threatened to have the resident beat up was not substantiated based on interviews with residents who stated they have never witnessed abuse at the facility, interviews residents who witnessed the resident with aggressive behaviors (including the resident of concern's roommate), interview with the named Caregiver, and review of incident reporting. Allegation #2: The resident was not bathed in a week was not substantiated based on observation of residents who appeared clean and well groomed, interviews with residents who stated they received regular showers, interview with the Public Guardian Representative of two residents, and interviews with a home health agency Registered Nurse (RN) and Certified Nursing Assistant (CNA) who stated the residents were always clean. The investigation into these allegations included: Observations on-site on 05/28/20 and 06/12/20, interviews with Caregivers, the Facility Manager, residents, a home health agency RN and CNA, and the Public Guardian Representative of two of the residents, resident record review, employee record review, and facility incident reporting. -Complaint #NV60974 with the following	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: REBECCA N. WOLFKILL | Title: Administrator | Date: 10/13/2020

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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	allegations was substantiated: Allegation #1: Resident sustained an injury of unknown origin: unexplained muscle tearing. There was no explanation for a bruise found on a resident's chest. See TAG Y853. The following allegation was not substantiated: Allegation #2: The facility was not adequately medicating the resident with thyroid medication was not substantiated based on review of medical records, physician's orders, and interview with the Caregiver that the facility followed the physician's orders. Allegation #3: Resident abuse: A male Caregiver was seen being abusive to a resident in the past was not substantiated based on interview with residents who stated they have never seen or experienced physical abuse at the facility, interview with the named Caregiver, and review of facility incident reporting. The investigation into the allegation included: Observations on-site on 05/28/20 and 06/12/20, interviews (with Caregivers, the Facility Manager, residents, a Public Guardian Representative, and a visiting Home Health RN and CNA), and review of resident records. -Complaint #NV00060440 with the following allegations was substantiated: The allegation a resident sustained severe bruising on the right leg and shoulder, did not receive proper medical attention until 2 days after the fall, and staff could not explain the bruises was substantiated. See TAG Y853. 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:			

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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 interview and record review, the facility admitted and retained one resident who was bedfast (Resident #9). Findings include: Resident #9 (R9) R9 was admitted to the facility on 03/23/20. R9 was transferred to the Veteran's Administration (VA) Hospital on 05/19/20. On 06/12/20 in the afternoon, the Caregiver / Manager (Employee #2 - E2), Caregiver (Employee #3 - E3), and the Administrator indicated R9 had gangrene on the right foot, was "deadweight" and required two people to transfer. Severity: 2 Scope: 1	0620	a) Resident #9 was admitted 3-23-20 is under the care of VA doctor, During Pandemic making appointment was done on facetime only. . Resident 9 had gangrene on right foot and deadweight and incapable of changing his position in bed without the help of 2 other people. b)The facility will not admit resident with a prohibited condition (Bedfast) Per NAC 449.2702 (4)(a). c) The owner and administrator will monitor for compliance. d) 6-12-20	10/13/2020
0820 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or (c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. Inspector Comments: Based on interview	0820	a) Resident #9 admitted 3-23-20 and discharged 5-9-20 had an open wound. There was lack of cooperation from VA doctor. The facility can not complete the WAIVER until the doctor complete the documentation and assessment , plan of care from a Home Health or NP that requires seeing the Resident physically. b) The facility will not admit any resident with a prohibited condition. Open wound and is not in a healing condition. c)The Owner and Administrator will monitor for compliance. d) 6-12-20	10/13/2020

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	and record review, the facility admitted and retained one resident with a wound (Resident #9). Findings include: Resident #9 (R9) R9 was admitted to the facility on 03/23/20. R9 was discharged to the Veteran's Administration (VA) Hospital on 05/09/20. R9's chart contained a Caregiver's note dated 03/23/20 which documented "(R9) was admitted to the facility, check the body, (R9) does have gangrene right foot. Call PCP VA (Primary Care Physician) to make appointment but only for Facetime video; call May 5, 2020." The facility did not submit an exemption request to the Bureau to admit and retain a resident with an open wound. There was no documentation of an assessment and treatment by a Home Health Nurse for the period of 03/23/20 through 05/09/20. On 05/28/20 in the afternoon, the Caregiver / Manager (Employee #3 - E3) verbalized R9 was admitted with gangrene to the right foot. The foot was black, yellowish, and dry, and had a bad odor. E3 acknowledged there was no treatment plan for the care of the right foot and no documentation of a home health nurse providing care for the foot. Severity: 2 Scope: 1			
0853 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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This	0853	a) Resident #10 incident happened on 3-14-20 Attachment #1 which is Saturday. The owner called the NP the same day of incident. (Attachment #2a 2b) The husband also present because the husband visit everyday when the owner calling the NP. NP's response was she doesn't work on weekend. She will see her Monday 3-16-20. NP came The husband indicated that he doesn't wand the wife to go to hospital (attachment #3)because of COVID-19. NP also ordered Ultrasound done 0n 3-17-20 (attachment #4)and blood drawn 3-18-20 per daily log (attachment 5). The Aspirin been stopped. Resident #11 there was 2 incidents .3-20-20 while watching TV and in his room 1-21-20 .b) The facility developed and implement a written Policy and Procedures Tag Y853 (attachment #6) c) The owner and Administrator will monitor	10/13/2020

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	record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on interview, record review, and document review, the facility failed to maintain evidence the facility sought medical care in response to bruising to the chest of one resident (Resident #10, Resident #11). Findings include: Resident #10 (R10) R10 was admitted to the facility in January 2020. There was a facility incident report dated 03/14/20 with a diagram which documented bruising to the right breast, front - middle of breasts, and scattered bruising to the upper neck. The facility Manager indicated she did not know how the bruising occurred. There was no documentation the physician was notified and the facility sought medical care for R10. Hospital medical records documented R10 was sent to the hospital on 03/21/20. The medical records upon assessment on 03/21/20 documented the following, in part: H&P (History & Physical): (R10) presented with report of AMS (altered mental status) and was found to have multiple upper chest ecchymoses with hematoma and pectoralis muscle injury on CT chest...Problem List / A&P (Assessment & Plan): Chest wall hematoma, chronic leukocytosis, dementia...CT (Computer Tomography) chest suggestive of traumatic injury rather than spontaneous bleed. Patient is non-ambulatory..." The facility Manager verbalized, "In March R10 passed out and changed color." The Manager was unable to provide information why the facility did not notify the physician and failed to seek medical attention for R10 on 03/14/20 upon identifying the bruises. Complaint #NV00060974 Resident #11 (R11) R11 was admitted to the facility in December 2019. The facility's incident report dated 01/21/20 documented the resident had a fall. There was lack of documentation the resident notified the physician of the fall. The resident was not transferred for medical attention until		for compliance. d) 6-12-20	

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	01/23/20. On 06/12/20 at 4:00 PM, the Facility Manager and the Caregiver had different explanations of when and how the fall occurred. The Caregiver first indicated R11 fell from the wheelchair in the living room. The Facility Manager and the Caregiver subsequently indicated R11 was found on the floor in the bedroom on 01/21/20 at 4:00 AM. The Facility Manager and the Caregiver reviewed photographs from the Home Health Agency showing dark bruising to the right shoulder and right upper leg. The Facility Manager and the Caregiver verified the resident did sustain bruises, and they did not know how the bruises occurred, and did not notify the physician and seek medical care for R11 when they noticed the bruises. Complaint #NV00060440 Severity: 2 Scope: 1			

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0876 SS= D	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. Inspector Comments: Based on interview and record review, the facility failed to ensure a written ultimate user agreement was completed for one resident (Resident #8). Findings include: Resident #8 (R8) R8 was admitted to the facility on 05/22/20. On 05/28/20, it was verified with Employee #4 (E4) the facility was administering medications to R8. There was no signed ultimate user agreement for R8. Severity: 2 Scope: 1	0876	a)The resident #8 is under Public Guardian. Resident #8 can't be able to sign so the public Guardian email the signed Permission to Administer to the Owner. Somehow the email from Public Guardian was lost and can not be retrieve the day of inspection. The Public Guardian sign the Ultimate User's Agreement the day before the resident moved in the facility. Attachment #7 b) Upon admission of resident to the facility Resident or Family has to sign Ultimate User's Agreement before the medications are given to resident. c) Owner and Administration will monitor for compliance. d) 6-12-20	10/07/2020
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 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	0878	a) Resident #1 had a skin allergy. It was not filled for the reason that the allergy was gone. The doctors order was indicated that if the medication is only available.(Attachment # 6) b) We had a meeting After Surveyor left. Whenever a resident return to the facility and has a new Prescription order the employee in-charge for medications has to fax the new RX order to the pharmacy. c) The Owner and Administrator will monitor for compliance. d) 6-12-20	10/07/2020

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	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, and record review, the facility failed to fill and administer medications per physician's orders for one resident (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 02/15/19 with diagnoses including insomnia and depression. R1 was transferred to an acute care facility on 03/08/20 and readmitted to the facility on 04/01/20. The physician's orders dated 04/01/20 documented, Benadryl, 25 milligrams (mg) three times daily. On 05/28/20, there was no Benadryl in R1's medication box. The Caregiver (Employee #4 - E4) verbalized she had forgotten to fill the Benadryl. E4 contacted the pharmacy, and verified the Benadryl was not filled. The Benadryl was not administered to R1 for the period of 04/01/20 through 05/28/20.			

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	Severity: 2 Scope: 1			
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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 -- of 8 residents (Resident #3, -----). Findings include: Resident #3 (R3) R3 was admitted to the facility on 09/27/19 with diagnoses including schizoaffective disorder and history of acute kidney injury. There was no documented evidence of initial 2-step tuberculin testing.	0936	a) Resident #3 had initial 2 Steps TB Test on file during the survey. Somehow the date is misprinted . (Attachment #7 and 8) b) When the facility admit a new resident the initial 2 steps TB Test has to be completed upon admission.(Quantiferon 10-08-20 attachment Y936) c) The Owner and Administrator will monitor for compliance. d) 6-12-20	10/13/2020