STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9278	A. BUILDING _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTERNATIVE HOME CARE	4504 LA ROCA CIRCLE, LAS VEGAS, NEVADA ,89121

(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 annual State Licensure survey, conducted at your facility on 10/24/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is currently licensed for ten Residential Facility for Group beds with mental illness and/or chronic illness, Category II residents. The census at the time of survey was nine. Nine resident files were reviewed and three employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Division of Public and Behavioral health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state and local laws. The following deficiencies were identified:	0000		
0871 SS= D	Medication Administration - Plan - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is	0871	Owner and Administrator held a training for staff 10/28/2019, at 4:00 p.m. At this meeting, they re-trained staff about medication administration emphasizing on reviewing medication on a daily basis and communicate routinely with the prescribing physician concerning issues or observation relating to the ordered medications, A communication notes has to be done and documented if an employee and caregiver communicated with the physician regarding medications that has concerns i.e adverse or allergic reactions to resident. Administrator is the responsible person to ensure all the plan of correction is implemented and will do a weekly audit of all medications to avoid future issues. Corrective action was done and completed 10/28/2019.	10/28/2019

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	in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician or other physician of the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on observation, interview and record review, the administrator failed to maintain a plan of care for a resident with a reported history of adverse reaction to a as needed medication for 1 of 9 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 01/04/19, with diagnoses of dementia. R4's Medication Administration Record (MAR) dated October 2019, documented the resident was allergic to Acetaminophen. A review of R4's medication revealed, the resident had been prescribed Acetaminophen 325 milligrams (mg), take two tablets by mouth every six hours as needed for pain. R4's medication box contained a bubble pack of Acetaminophen 325 mg. On 10/24/19 at 12:00 PM, a Caregiver acknowledge R4 was allergic to the medication. The Caregiver verified the medication was in R4's medication box. The Caregiver explained the facility had informed the physician the resident was allergic. Severity: 2 Scope: 1			

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0872 SS= D	Medication Educ Initial/annual Administrator - NAC 449.2742 -Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training. (g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training. (h) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on personal file review and interview, the facility failed to ensure an Employee received the initial 16 hours medication management training (Employee #1). Findings Include: Employee #1(E1) Employee #1 was hired on 01/14/19. The employee record lacked documented evidence 16 hours of Initial Medication Management was completed. On 10/24/19 at 12:30 PM, the Owner could not locate the 16 hour Medication Management certificate. The Owner verbalized E1 had the certificate, prior to being hired. The Owner confirmed the certificate should have been located in the employee record. Severity: 2 Scope: 1	0872	Owner and Administrator held a training dated 10/28/2019 at 4:00 p.m. At this meeting, it was discussed that ALL caregiver need to comply an initial 16 hours training on medication management on his or her first year of employment consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and must obtain a certificate. After receiving an initial training, one needs at least 8 hours of training in management of medication. Caregiver and employees that was unable to comply must be off from schedule until all requirement were met. Administrator is the responsible person to ensure the plan of correction is implemented and thorough screening of ALL required certificates are complied by an employee and caregiver upon hire and do a monthly audit of employee and caregiver file to make sure all required documents are up to date and valid. Corrective action was completed 10/28/2019	10/28/2019
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	0878	Owner and administrator held a training for staff on 10/28/2019 at 4:00 pm. At this meeting, they both re-trained staff about Medication Administration that one must at all times review the medication on a daily basis before administering it to the resident and be aware of change of order or any medication that medication bottle does not match physician order. Always comply with	10/28/2019

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	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 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 ensure a medication was administered as prescribed to 1 of 9 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 05/19/18, with diagnoses including depression and hypertension. A bottle of Isoniazid 300 milligrams (mg) found in R1's medication bin was written in Spanish. The bottle read give one tablet on Mondays and Thursday. The October 2019 Medication Administrator Record (MAR), documented give one and a half tablet by mouth twice a week on Monday and Thursday. On 10/24/19 at 12:00 PM, the Caregiver		the order, indicate on the container of the medication that change has occur, note the change in the record maintained, within 5 days after the change is ordered the copy of the order or prescription signed by the physician must be included in the record maintained, if the label prepared by pharmacist does not match the order or prescription written by 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. Administrator is the responsible person for ensuring that plan of care is implemented. Administrator will do weekly audit of medications to avoid future issues. The corrective action was completed 10/28/2019	

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	confirmed the medication bottle was in Spanish and did not match the MAR. The Caregiver was unsure why the medication bottle was written in Spanish and did not match the MAR. Severity: 2 Scope: 1			
0886 SS= D	Medication Administration - Responsibility - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 10. The administrator of a facility is responsible for any assistance provided to a resident of the residential facility in the administration of medication, including, without limitation, ensuring that all medication is administered in accordance with the provisions of this section. Inspector Comments: Based on observation, record review and interview, the Administrator failed to be responsible for medications administered to a resident (Resident #3 and #7). Findings include: Resident #7 (R7) R7 was admitted on 8/30/19, with diagnoses including muscle weakness and amyotrophic lateral sclerosis (ALS). On 10/24/19 at 9:30 AM, medications were observed in a medication cup on the resident's bedside table. R7 indicated the staff had left the medication on the table. R7 explained R7 was not ready to take the medications. Resident #3 (R3) R3 was admitted on 10/1/19, with diagnoses including hypertension and chronic kidney disease. R3 was under the care of hospice. On 10/24/19 at 11:30 AM, a hospice nurse found medications in R3's pocket not taken and indicated R3's blood pressure was elevated. On 10/24/19 at 11:35 AM, R3 explained staff had brought the medications in his bedroom and did not watch him take the medications. On 10/24/19 at 11:40 AM, a Caregiver/Owner confirmed medications were left unattended in both residents room. The Caregiver/Owner indicated the medications should not have been left in the residents room. Severity: 2 Scope: 1	0886	Owner and administrator held a training for staff on 10/28/2019 at 4 pm. At this meeting, they both re-trained staff on medication administration and that all medication is administered in accordance with the provisions. Never to leave the medication with the resident. Everyone should make sure that resident took all his/her medication before attending to other residents. Make sure all medication are taken. The caregivers on duty are responsible for medication left on patients room, dining table, patient pockets. Administrator and owner will conduct a random inspection and any employee and caregiver on duty will be reprimanded if any of this incident will occur. Administrator is responsible for ensuring the plan of care is implemented. The date corrective action was completed was 10/28/2019	10/28/2019