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 _____ | **08/06/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A BENEVOLENT HEART CARE HOME** | **508 PEARBERRY AVENUE, LAS VEGAS, NEVADA ,89123** |

| (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 |
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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 08/06/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness, Category II residents. The sample size was seven. One complaint was investigated. Complaint #NV00060759 could not be substantiated. Allegation #1 -The facility unnecessarily discharged a resident was unsubstantiated based on interviews with two caregivers, a resident, the owner, and the Administrator. Document review of incident reports and a 30 day notice of eviction. Allegation #2 - Staff were not qualified was unsubstantiated based on record review of employee files revealed proper documentation of training, background checks, and other staff file information. Allegation #3 - The caregivers at the facility were verbally and physically abusive was unsubstantiated based on observations of caregivers providing care to residents and interviews with three residents, two caregivers, the owner and the Administrator. Allegation #4 - The caregivers at the facility neglected the resident was unsubstantiated based on observations of caregivers providing care to residents and interviews with three residents, two caregivers, the owner and the Administrator. The investigation into the allegations included: Observation of caregivers providing care to residents and interacting with the residents. Interviews were conducted with three residents, two caregivers, the owner and the Administrator. Review of five resident files including the resident of concern and three employee files. Document review of the 30 day notice of eviction and incident reports. | 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRISTOPHER LANE Title: Administrator Date: 08/22/2020

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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| | 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: | | | |
| 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 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 | 0878 | **1)** We have corrected the specific findings in the SOD by the Administrator meeting with the Medication Technician on duty at the time along with the Owner to discuss the findings. An admittance of an error was made by the Med Tech when she asked a non-Med Tech Caregiver for assistance with resident medications by placing the medications in a cup to be delivered on a tray to residents #2 & #3 and expecting the caregiver to assist correctly. It was agreed that in the future she would call for assistance to ownership if a demand on her time during morning medications was so great that she could not deliver medications herself over the 30 minutes before and 30 minutes after the allotted time of 8am. As Residents #2 & #3 did not go to the table for their meal and were being fed in their room, the Med Tech also was giving Meds to the others in the dining room at the same time. She admitted she could have delivered the medications to the residents in their respective rooms a bit later but resident #2 was expecting the Med delivery exactly at the routine time which stressed the Med Tech to where she made the error. There is no excuse as trained assistance is just a few minutes away, if needed.<br>**2)** As she was trained in proper medication delivery in both the 8 Hour refresher and the in-house annual Medication Plan, and has many years of experience, it was not a matter of not being trained. The Med Tech was stressed and made a bad error in judgement to try and meet the exact time for routine medication deliveries. However, the Administrator did go over the Medication Plan again with the Med Tech | 08/06/2020 |

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| | 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.<br><br>Inspector Comments: Based on observation, interview and record review, the facility failed to ensure medications were given as prescribed for 1 of 7 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted on 02/29/20, with diagnoses including chronic obstructive pulmonary disease and anxiety. On 08/06/20, Resident #2 was lying in bed eating lunch. A pill cup was on the lunch tray with Resident #3's name on it. Resident #2 held the medication cup and indicated the name on the cup was not her name. On 08/06/20, Caregiver #1 and #2 verified the name on the medication cup was not Resident #2. The Caregivers verified by checking the medication in the cup against Resident #2's noon medication and identified it did not belong to Resident #2. The caregivers acknowledged the wrong medication had been given to the wrong resident. Severity: 2 Scope: 1 | | and Ownership, especially Section 4, and NAC 449.2742, to reinforce the "assistance" of medications regulations.<br>**3)** the Administrator will make his 2-3 visits a week to the facility at unannounced times more in line with the times of daily medication deliveries to better monitor these regulations.<br>**4)** The Administrator will be Responsible for seeing the deficient practice does not occur again.<br>**5)** Corrective action meeting was immediate after inspection: 8/06/20 | |

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| 0923 SS= D | Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 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.<br><br>Inspector Comments: Based on interview and observation, the facility failed to ensure medications were given as prescribed for 1 of 7 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted on 02/29/20, with diagnoses including chronic obstructive pulmonary disease and anxiety. On 08/06/20, Resident #2 was lying in bed eating lunch. A pill cup was on the lunch tray with Resident #3's name on it. The resident was left unattended to take her medications. On 08/06/20, the Caregiver acknowledged the medications were delivered on the lunch trays and she did not monitor the resident to make sure the medication had been consumed. Severity: 2 Scope: 1 | 0923 | **1)** The findings noted in the SOD are not standard practice and were not a question of lack of training or experience, but were caused by an error in judgement by the Med Tech on duty which she admitted. The Administrator did discuss this after the inspection as the Med Tech, Caregiver and Owner were all at the facility. It was agreed that an error was committed and one which will never be made again. Med Tech agreed to notify owner when the demands of the shift require assistance, and that the assistance can be given in as little as a matter of minutes due to the proximity of backup staff.<br>**2)** We all agreed that it is not a sign of weakness if the shift needs additional staff due to resident behaviors or demands that are not routine. The Med Tech on duty will make the call for assistance with medication delivery if the situation warrants, instead of repeating a potentially dangerous judgement error.<br>**3)** The Administrator will make unannounced visits to the facility 2-3 times a week during Medication Administration times, in order to better monitor compliance of medication deliver regulations.<br>**4)** The Administrator will be responsible for this deficiency not recurring.<br>5) Action completed via meeting after inspection on 8/06/2020. | 08/06/2020 |