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 _____	**10/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASI SPENCER	**4148 SPENCER STREET, LAS VEGAS, NEVADA ,89119**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure Annual Grading survey and Complaint Investigation survey conducted at your facility on 10/11/22 through 10/12/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for 40 Residential Facility for Group beds with endorsements for mental illness, chronic illness, intellectual disabilities, and assisted living services, 10 Category I and 30 Category II residents. Eleven resident records and twelve employee records were reviewed. The facility received a grade of A. One complaint was investigated: Complaint #NV00067074 with three allegations was substantiated. Allegation #1: A resident was given the PM medications instead of the AM medications, became tired, and had to miss therapy was substantiated. See TAG Y0878. Allegation #2: A dependent resident felt uncomfortable when being assisted with toileting and showering was unsubstantiated based on interviews with four residents who indicated assistance during incontinence care and showering was appropriate and they liked the staff very much. Interviews were conducted with the Administrator and the Service Care Coordinator, who verified received a notification by the Day Program that the family member of the resident reported concerns six days after discharge and the facility investigated and did not validate the concerns. Document review and record review included the resident's signed Grievance Procedure and the Resident Rights upon admission. Allegation #3: A resident tipped over backwards in the wheelchair and hurt themselves when getting onto the lift in the van was substantiated. See TAG Y0515. The investigation into the allegations included: Interviews with four residents, the Administrator, and the Service Care	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: SHELLE SPONSELLER | Title: Administrator | Date: 11/04/2022

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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	Coordinator, record review of twelve resident records, including the resident of concern, and review of admission policies and procedures. 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 were identified:			
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on observation, interview, document review, and record review, the facility failed to ensure one resident received protective supervision during transport assistance for one of 11 sampled residents (Resident #11). Findings include: Resident #11 (R11) R11 was admitted to the facility on 08/01/22 with diagnoses including status post-acute hypoxic / hypercarbic respiratory failure and encephalopathy. An incident report dated 08/03/22 documented R11 was being transferred from the facility van to the ground in a manual wheelchair, the wheelchair tipped, and R11 fell backwards. On 10/11/22 at 12:15 PM, the Rehabilitation Coordinator verbalized the proper way to transfer a resident with a wheelchair from a van onto a lift was to unlock the wheelchair from the van, then propel the resident in the wheelchair to the entrance of the lift, ensuring the resident's seat belt was on and the manual brakes on the wheelchair were set. The staff exited the van, walked around and activated the lift, released the wheelchair brakes, and assisted the resident down the lift. The Rehabilitation Coordinator indicated a resident with a	0515	1) New transportation safety training was developed to address deficiencies that were identified following the reported incident. All staff who provide transportation were required to participate in training and documentation of re-training is maintained in their supervisory file on site. 2) Transportation safety training will be required annually for all staff providing transportation to those residing at ASI Spencer Street. Supervisor and Administrator will assure that all transportation staff participate in this training and documentation of such remains on site. 3) Care Coordinator, Site Supervisor and Administrator will complete unannounced observations of staff while in the transportation process to ensure that procedures are followed as trained. Staff will also be randomly selected to demonstrate safe transportation processes. 4) Care Coordinator, Site Supervisor, Administrator 5) 08/15/2022 revised training safety protocols were developed and put into place. All current staff were re-trained by 9/01/2022. New hires are trained prior to consent to transport individuals. 6) Transportation Training Checklist	09/01/2022

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	diagnosis of cognitive impairment or brain injury should not have independently propelled the wheelchair or have had their seatbelt off during the lift transfer process. On 10/11/22 at 1:00 PM, the Service Coordinator verified the incident occurred on 08/03/22 and R11 reported having elbow pain and discomfort following the incident. The Service Coordinator indicated the facility investigated the incident and the Driver received training following the incident on safe wheelchair transfers. On 10/12/22 at 9:30 AM, the Driver acknowledged on 08/03/22 R11's wheelchair was not buckled, as required. R11 was positioned in the wheelchair in front of the lift, the Driver exited the vehicle to unfold the lift, and then asked R11 to move the wheelchair forward, instead of ensuring the manual brakes were set. When R11 propelled forward, the front wheels hit the ramp, and R11 tipped backwards. The Driver verbalized the normal approved practice was to unfold the lift first, then return to the interior of the van to assist residents onto the lift. Once the resident was on the lift, exit the van to operate the lift controls, and finally assist the resident off the lift. The Driver acknowledged not using proper transfer procedures from the van to the lift with R11, who was in a wheelchair. The Driver acknowledged the Driver had not assisted R11 down the lift, as required. Severity: 2 Scope: 1 Complaint #NV00067074			
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	0878	1) Staff involved in medication incidents were removed from their responsibility to assist with medications until retraining in Medication Administration is completed. Documentation of retraining maintained in supervisory file on site. Missing MAR documentation was located and staff who observed self-administration of medications completed documentation as required. MAR was revised to reflect orders as written by physician and staff were advised of medication time changes, so that	11/01/2022

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	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 interview, record review, and document review, the facility failed to ensure medications were administered per physician's orders for 3 of 11 sampled residents (Resident #4, #7, and #11). Findings include: Resident #4 (R4) R4 was admitted to the facility on 11/12/20 with diagnoses including anoxic brain injury and diabetes mellitus. The physician's order dated 05/12/22 documented Trulicity, 1 injection weekly. There was no documentation R4 self-administered the Trulicity in the first week of October 2022. The last documented administration was dated 09/30/22. On 10/11/22 at 1:00 PM,		medications were given as prescribed and not TID. 2) ASI has hired designated staff whose sole responsibility will be to specialize in medication administration. These staff will meet monthly to review medication administration protocols and processes. Management staff was retrained on medication administration procedures; to include review of MARS to ensure that documentation is present for all prescribed medication and that the MARS match the orders as they are prescribed by the physician. Portability documents will no longer be completed based on discharge documents and will be created off Intake Documentation to eliminate any discrepancy in medication lists. Medication Quality Assurance position was developed to provide on-going analysis and review of Medication Administration and to assure that Medication Administration protocols are followed as written. 3) Medication QA will provide daily review of Medication Intake, Medication Administration, Medication Refill and Medication Discharge processes. Errors and inconsistencies will be resolved with the physician and pharmacy. Care Coordinator will provide ongoing supervision and training of Medication DSP staff to ensure their compliance with the Medication Administration process as described in the Medication Administration Policy and Procedure. Administrator will complete impromptu audits of medication administration processes to assure compliance. 4) Medication Quality Assurance, Care Coordinator, Administrator 5) As of November 01, 2022, MARS were revised as needed; staff re-training was completed; all positions have been hired and trained; necessary procedures and	

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	the Administrator and the Service Coordinator verified the October 2022 Medication Administration Record (MAR) lacked documentation of R4's self-administration of the Trulicity. Resident #7 (R7) R7 was admitted to the facility on 09/14/22 with diagnoses including post cerebral vascular accident with right sided weakness. The physician's order dated 09/13/22 documented Hydralazine, 50 milligrams (mg), take one tablet by mouth every eight hours. The MAR's for September and October 2022 documented the Hydralazine was administered three times daily at 6:00 AM, 12:00 PM, and 6:00 PM. On 10/11/22 at 1:15 PM, the Service Coordinator verified the Hydralazine was not administered every eight hours as ordered by the physician, and was given every six hours in error. Resident #11 (R11) R11 was admitted to the facility on 08/01/22 with diagnoses including status post-acute hypoxic / hypercarbic respiratory failure and encephalopathy. -A physician's order dated 08/01/22 documented Bupropion, 75 mg, 1 tablet by mouth every night. A Medication Incident Report dated 08/03/22 at 9:00 AM documented the Medication Technician went to give R11 morning medications and accidentally gave R11 the night medication (Bupropion). On 10/11/22 at 1:30 PM, the Care Coordinator verified administration of the Bupropion in the morning did not follow physician's orders and was a medication error. -On 10/11/22 at 1:30 PM, the Administrator and the Service Coordinator verified R11's admission medication orders were reviewed upon R11's admission and transcribed onto the resident's Portability Profile, dated 08/01/22, as follows: -Alprazolam, 0.25 mg, 1 tablet by mouth every 8 hours. -Bupropion, 75 mg, 1 tablet by mouth at bedtime. -Clonazepam, 0.25 mg, 1 tablet by mouth every eight hours. -Ipatropium Bromide / Albuterol Sulfate, 3 milliliters (ml) every six hours as needed. -Atomoxetine, 80 mg, 1 tablet by mouth. -Hydrochloride, 1 tablet daily. -Thiamine, 100		protocols were updated. 6) N/A	

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	mg, 1 tablet by mouth daily. -Trazadone, 50 mg, 1 tablet by mouth at bedtime. -Folic Acid, 1 mg, 1 tablet by mouth daily. -Senna, 2 tablets by mouth every 12 hours. -Valproic Acid, 250 mg three times daily with meals. -Melatonin, 3 mg by mouth at bedtime as needed. -Guaifenesin with Codeine, 10 ml by mouth every six hours as needed. -Heparin, 5000 mg subcutaneously every six hours. -Opthalmic Lubricant, apply 1 drop every eight hours. The October 2022 Medication Administration Record (MAR) documented the following six medications: Acetaminophen, Alprazolam, Folic Acid, Escitalopram, Bupropion, and Valproic Acid. There was no documentation the facility clarified the admission physician's orders for medications, which had been transcribed onto the Portability Profile dated 08/01/22. On 10/11/22 at 1:30 PM, the Administrator and the Service Coordinator acknowledged the physician's orders were not clarified upon admission and the MAR was inaccurate and incomplete. The Service Coordinator reported R11 arrived at the facility with the six medications listed on the October 2022 MAR, and the facility did not clarify the medications ordered by the discharging facility with the physician and the pharmacy, per the facility's policy. The Medication Management Policy, revised 07/01/20, documented all new admissions to the facility will be required to have their physician complete a Medical Clearance and Authorization for Medical Administration prior to moving into the community. The MCS (Medication Certified Staff) will compare the provided medications with the Physician's Order in the chart to ensure that all medications are available. Severity: 2 Scope: 1 Complaint #NV00067074			