STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10340	A. BUILDING _____ B. WING _____	07/15/2021

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PROCARE HOSPICE OF NEVADA LLC	**8025 AMIGO ST, LAS VEGAS, NEVADA ,89123**

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0000	INITIAL COMMENTS Inspector Comments: This Statement of Deficiencies was generated as a result of an initial State Licensure Survey conducted on 07/08/2021 and on 07/15/2021, in accordance with Nevada Administrative Code, Chapter 449 Provisions of Hospice Care. Observations were conducted in the patient care areas, including 14 private rooms designated for inpatient hospice care, two rooms designated for use by family members, the kitchen, the laundry room, a storage room, and the medication room. Seven personnel records were reviewed including the administrator, director of nursing, director of social services, inpatient (IPU) nurse manager, two registered nurses (RN), and a certified nursing assistant (CNA). The facility also had a chief financial officer, director of spiritual services, director of quality and education, director of human resources, director of program development, volunteer coordinator, dietitian, facility maintenance technician, another RN, and another CNA in their current employee roster. The facility utilized an electronic system for the patient's medical or health records. The electronic health record (EHR) included the patient's face sheet (demographics), referral, consents, allergies, physician's orders, plan of care, progress notes, communication notes, medication administration record, and treatment record. The RN Clinical Coordinator revealed each clinical staff member would have been provided with an electronic device to be used in documenting in the patient's EHR. The electronic device would have been stored in the medication room after each shift or if not in use by the designated staff member. Each staff member would have created their own password to access the EHR, and to maintain security and confidentiality of the patient's EHR. A review of the list of the facility's contracted services was conducted. The facility maintained a current contract or agreement with an outside vendor for services such as pharmacy including dispensing and clinical consulting, durable medical equipment,	0000		

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	medical waste disposal, hospital transfer agreement, radiology, laboratory, medical transport, equipment preventive maintenance, pest control, and therapy. The following policies and documents were reviewed: Compliance with Regulations policy, Scope of Services policy, IPU - Tuberculosis Protocol policy, IPU - Diets (General) policy, IPU - Operation of the Inpatient Unit policy, Admission to IPU policy, Bereavement Services policy, Continuity of Care policy, Dietary Services policy, Homemaker Services policy, Hospice Aide Services policy, Medical Supplies policy, IPU - Patient Specific Controlled Drug Disposal policy, Nursing Services policy, Physical, Occupational, Speech and other Therapies policy, Plan of Care - Content policy, Social Work Services policy, Spiritual Care Services policy, Volunteers - Services policy, Interdisciplinary Group policy, Infection Control Program/Plan, Infection Control - Standard and Transmission-Based Precautions policy, Emergency Preparedness Program - Pandemic Safety Measures Employee and Patient Screening policy, Emergency Management Program, IPU - Biomedical Infection/Exposure Control Plan policy, Abuse, Neglect, Mistreatment and Exploitation policy, Grievance Procedure policy, Governing Body policy, Personnel Records policy, Patient Admission Packet, and Employee Handbook. 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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0057	449.0184 - GOVERNING BODY REQUIRED; DUTIES OF GOVE - Every facility which provides a program of hospice care must have a governing body which shall: 2. Ensure that all services provided by the program of hospice care are consistent with accepted standards of practice for the care of the patients. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure the medications stored inside an emergency box (eBox) located in the medication room were not expired. Findings include: On 07/15/2021 at 9:54 AM, an inspection in the medication room was conducted with the Director of Nursing (DON). Five bottles of Atropine 1% oral solution 5 milliliters (ml) with an expiration date of 01/02/2021 were found inside the eBox located in the medication room. The DON confirmed the findings and explained the medications were delivered on 07/14/2021. The DON acknowledged the expired medications should have been discarded. The facility's policy titled IPU (inpatient care unit) - Medication Administration and Destruction, undated, documented expired prescription medications were not available for use and should have been properly disposed of. All medications and supplies should have been checked for expiration.	0057	1) How will you correct the specific finding stated in the SOD? --Per Policy and Procedure IPU.M20, "IPU - Medication Administration and Destruction", ProCare Hospice of Nevada will check for expiration dates of medications received from the pharmacy upon delivery, ensuring no expired medications are dispensed to patients. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur? --In addition to abiding by the aforementioned policy and procedure, ProCare Hospice of Nevada uses the IPU Medication Log form for receiving medication into the inpatient unit. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: --All medication will be reviewed by an RN or LPN upon delivery from the pharmacy to ensure they are not expired. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented: --Director of Nursing. If the Director of Nursing is unavailable, the Inpatient Unit Manager will be responsible. 5) The date the corrective action will be completed: --The corrective action was completed on July 15, 2021. 6) Supporting Documents: --Please see attached. 7) N/A	07/15/2021
0082	449.0187 - REQUIREMENTS FOR OPERATION OF FREESTAND - A freestanding facility for hospice care must comply with the following requirements: 10. An anteroom, a room adjoining the room of each patient or a private area must be provided and furnished with a bed and chairs for use by the members of the	0082	1) How will you correct the specific finding stated in the SOD? --ProCare Hospice of Nevada will install privacy curtains in the patient bedroom providing privacy for the family member. A recliner/sleeper is present in family	08/13/2021

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	patient's family. Inspector Comments: Based on observation and interview, the facility failed to ensure each patient room was provided with a private area furnished with a bed and chairs for members of the patient's family and that the privacy device was manufactured with fire-resistant material. Findings include: On 7/8/2021 during a tour of the facility, partitions were observed in the patient rooms. The partitions were observed to be transparent and did not provide sufficient privacy for the members of the patient's family. The Director of Program Development was interviewed and indicated there was no documentation of the fabric's fire resistance rating. On 07/15/2021 during the morning, the in-patient care areas were inspected, including 14 bedrooms designated for inpatient hospice care, 2 rooms designated for use by family members, the kitchen, a storage room, and the medication room. The patient's bedrooms were single occupancy, furnished with a clinical bed, a nightstand, bedside table, and a comfort recliner. The rooms had a private restroom with shower, and a closet to store patient's belongings. The rooms did not have an anteroom or an adjoining room to accommodate the family members. The rooms did not have designated spaces within the inpatient rooms to accommodate a bed for use by family. There were two rooms designated for family meetings, the family room, and the spiritual room. Both rooms were furnished with chairs and sofas. The rooms did not have beds for use by family. The Director of Program Development acknowledged private area for each patient's family was not available, only the two rooms described above. There were no other spaces available in the event more than two family groups simultaneously required a private area for grieving process.		space, chairs available. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur? --The privacy curtains are permanent and will be available in each room for patient family use at any time. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: --The privacy curtains are installed and stored in the patient room. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented: --Director of Program Development 5) The date the corrective action will be completed: --August 13, 2021 6) Supporting Documents: --Please see the following attached: Drawing of the privacy curtains in patient rooms, product sheet for privacy curtains, and invoice for privacy curtains. 7) N/A	
9999	FINAL OBSERVATIONS Inspector Comments: Based on personnel record review and interview, the agency failed to provide tuberculosis testing as required under Nevada Administrative Code	9999	1) How will you correct the specific finding stated in the SOD? --The identified employees #2, #3, #5, #6, and #7 have received screenings for	08/02/2021

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	(NAC) 441A.375, for 5 of 19 employees (Employee #2, #3, #5, #6, and #7). Findings include: NAC 441A.375 Medical facilities, facilities for the dependent, homes for individual residential care and outpatient facilities: Management of cases and suspected cases; surveillance and testing of certain employees and independent contractors; counseling and preventive treatment, read in part: " ... 3. Before an employee or independent contractor described in subsection 2 first commences to work in a medical facility, a facility for the dependent, a home for individual residential care or an outpatient facility, the employee or independent contractor must have a ... (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee or independent contractor has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. An annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or a designee thereof determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination at least annually. 4. An employee or independent contractor described in subsection 2 who has a documented history of a positive tuberculosis screening test is exempt from screening with blood or skin tests or chest radiographs. Such an employee or independent contractor must be evaluated at least annually for signs and symptoms of tuberculosis. An employee or independent contractor who develops signs or symptoms which are suggestive of tuberculosis must submit to diagnostic tuberculosis screening testing for the presence of active tuberculosis as required by the medical director or other person in charge of the applicable facility or home, or his or her designee. 5. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines adopted by		TB using QuantiFERON or 2 step test on August 2, 2021. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur? --Pre-employment processes include a physical, 2 step screen and testing for TB. The company will hold an annual TB screening and testing annually for all patient care employees. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: --Monitoring will be coordinated by the Director of Human Resources in collaboration with the Director of Nursing. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented: --Director of Human Resources 5) The date the corrective action will be completed: --Initiation of TB testing and screening on August 2, 2021. 6) Supporting Documents: --Please see attached. 7) N/A	

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	reference in paragraph (g) of subsection 1 of NAC 441A.200. 6. A medical facility shall maintain surveillance of employees and independent contractors described in subsection 2 for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee or independent contractor must be evaluated for tuberculosis." A review of the personnel files of Employees #2, #3, #5, #6, and #7 lacked documented evidence tuberculosis testing was conducted on the staff that would have patient contact. Employee #2 (E2) A review of E2's personnel record revealed a QuantiFERON test (a blood test to help in the detection of tuberculosis) was performed on 02/26/2020. The test resulted negative for tuberculosis. The personnel record lacked documented evidence an annual tuberculosis test such as QuantiFERON, a tuberculosis skin test, or screening for signs and symptoms of tuberculosis was performed in 2021. Employee #3 (E3) E3's personnel record documented two skin tuberculosis tests performed on 07/10/2018 and 07/30/2018. The personnel record lacked documented evidence annual tuberculosis tests such as QuantiFERON, or a tuberculosis skin test, or screening for signs and symptoms of tuberculosis were performed in 2019 and 2020. Employee #5 (E5) E5's personnel records documented the employee was hired on 12/21/2020. The personnel record lacked documented evidence tuberculosis test such as QuantiFERON or two steps tuberculosis skin test was performed before commenced to work. Employee #6 (E6) E6 was hired on 07/20/2020. The personnel record revealed a negative skin tuberculosis test dated 04/11/2019. The personnel record lacked documented evidence tuberculosis test such as QuantiFERON or two steps tuberculosis skin test was performed before commenced to work.			

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	Employee #7 (E7) E7 was hired on 11/15/2018. The personnel record documented a positive skin test with 30 millimeters of induration. A chest X-ray was performed on 03/21/2018 with negative results for tuberculosis, and a questionnaire for screening signs and symptoms of tuberculosis was conducted on 11/15/2018. The personnel record lacked documented evidence screenings signs and symptoms of tuberculosis were performed annually thereafter in 2019, 2020, and 2021. On 07/15/2021 at 12:40 PM, the Director of Human Resources verbalized being unaware of the regulatory requirements for tuberculosis control in medical facilities. On 07/15/2021 at 1:00 PM, the Director of Nursing acknowledged the tuberculosis tests were not performed as described in the NAC 441A.375.			