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 _____	**01/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS ALZHEIMER AND MEMORY CARE 1	**3224 BRAZOS STREET, LAS VEGAS, NEVADA ,89169**

(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 the Complaint Investigation survey conducted at your facility on 12/13/19 through 01/08/20, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds with an endorsement to provide care for persons with Alzheimer's disease, Category II. The census at the time of the survey was 9. Complaint #NV00059565 with the following allegation was substantiated: Allegation #1: The resident has an ulcer on the sacral area. See TAG Y 823. The following allegation could not be substantiated: Allegation #2: Staff was moving the resident in a wheelchair and tied a bed sheet around the resident's waist to the back of handles on the wheelchair. The investigation into the allegation included the following: Observation of residents in activities of daily living and staff providing care and assistance. Interviews were conducted with two Caregivers, the Administrator, and two alert residents. Record review of nine residents, including the resident of concern. 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. Additional deficiencies were identified during the course of the complaint investigation survey. The following regulatory deficiencies were identified:	0000		
0050 SS= G	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive	0050	1. Upon the Public Guardian's directions, the Administrator sent R1 out to the ER and was admitted to an acute care facility on the 14th of December, 2019. 2. The administrator repeatedly made the Public Guardian aware that R1's insurance only allowed 3x/week Home Health RN	01/21/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRIS C. TAN Title: Administrator Date: 01/21/2020

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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	needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, interview, and record review, the Administrator failed to ensure one resident who was in a deteriorating condition was transferred to a higher level of care (Resident #1). Findings include: Resident #1 (R1) Based on interviews with the Administrator, two Caregivers and the Home Health Agency (HHA) Nurse, the resident was in a deteriorating condition for the past five days (R1 was lethargic, was not eating and drinking, was demonstrating pain, and was not receiving necessary services for the open sacral wound as prescribed by the physician.) R1 was admitted to the facility on 11/01/19 with diagnoses including dementia, encephalopathy, and sacral ulcers. On 12/13/20 upon entry to the facility at 2:15 PM, R1 was observed laying on the couch horizontally with non-sensical, garbled speech and moaning. The Caregivers indicated R1 had declined within the past week: R1 was refusing to eat and drink, the sacral wound had a really bad odor with a yellowish-brown discharge, and R1 moaned in pain when upon changing the brief and repositioning. Review of the resident's chart revealed there was a physician's order dated 11/27/19 for daily wound care to the sacral wound by a Registered Nurse (RN) as follows: "HHA Skilled Nurse to perform wound care. 1. Remove old dressing and cleanse with wound cleanser, pat dry. 2. Apply thin layer of MediHoney (or TheraHoney) over wound bed. Cover with Sacral foam dressing. Frequency: daily and PRN (as needed) if soiled." The Administrator indicated she was aware R1 was declining, and was frustrated at having to wait four more days to get an appointment for the Wound Care physician. The Administrator verified the HHA had not		visits. The administrator recommended that the HMO insurance be dropped because it does not cover daily RN visits. She should have recommended instead an immediate transfer of R1 to a higher level of care facility. 3. The administrator should ensure that a resident in a deteriorating condition be transferred to a higher level of care if the facility cannot provide all the necessary services appropriate to the condition of a resident. 4. The administrator. 5. 12/14/2019	

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	provided daily wound care to R1 as ordered by the physician, and indicated the Caregivers had made her aware that the HHA RN was only coming to the facility 3 times per week to perform wound care. On 12/13/20 at 3:00 PM, the Public Guardian was contacted by the Administrator to communicate R1's deteriorating status, indicators of pain and distress as demonstrated by moaning, and the foul odor from the sacral wound. The Public Guardian initiated a 3-way telephone call (to include the Public Guardian, the HHA Representative, and the Administrator). The HHA Representative indicated the only physician's orders they had on record were for a Home Health Skilled Nurse to treat the sacral wound 3 times weekly. The HHA Representative verified they were not aware of daily orders for a Registered Nurse to provide daily wound care. The HHA Representative further indicated that on 12/09/19 (four days earlier), the RN communicated to the physician regarding the sacral wound's foul odor and signs of infection, and the physician's response was a verbal order for antibiotics. The HHA Representative indicated the antibiotics were never filled. At the end of the telephone call the Public Guardian directed the Administrator to send R1 out to the Emergency (ER) Room at an acute care facility. Resident was admitted to the acute care facility on 12/14/19: The Acute Care Facility's History and Physical documented: "...Chief complaint: weakness, bedsore, loss of appetite and constipation x5 days from group home...past medical history of Alzheimer's dementia, chronic sacral ulcer, was brought in from the group home because patient not eating regular, weakness, constipation for 5 days. Emergency Room patient found to have infected sacral decubitus ulcer, was septic, dehydrated, got information from the ER physician and the group home record...Physical exam: Skin: Infected lower sacral ulcer with eschar necrotic tissue 7 x 8			

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	centimeters (cm). Assessment / Plan: Infected lower sacral decubitus ulcer, sepsis secondary to above, hyperkalemia, hyponatremia, Alzheimer's dementia, lactic acidosis, dehydration, protein calorie malnutrition, failure to thrive. Severity: 3 Scope: 1			
0823 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) 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician; (b) The condition must be cared for by a medical professional who is trained to provide care for and reassessment of that condition; and (c) Before a caregiver provides care to the person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer, the caregiver must receive training related to the prevention and care of pressure sores from a medical professional who is trained to provide care for that condition. Inspector Comments: Based on interview and record review, the facility failed to ensure treatment was provided as per physician's instructions for a resident with an open wound (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/01/19 with diagnoses including dementia, encephalopathy, and sacral ulcers. The Physician's Visit Summary dated 11/01/19 documented multiple sacral ulcers. The facility did not request a waiver for exemption prior to R1's admission. Following the annual survey on 11/12/19, R1 was identified as having an open wound. The facility received a Statement of Deficiencies with the citation that the facility admitted and retained a resident with an open wound and did not	0823	1. The facility/caregiver requested the Home Health Nurse to provide wound care notes to be submitted with the waiver exemption request. The HH Nurse did not have any notes and said will ask their office about it. The caregiver suggested some forms but the Nurse waited for her office's response. R1 then was sent out to the ER and was admitted to an acute care facility on 12/14/19. 2. It was clear that the physician's order for the frequency of wound care was "daily and PRN if soiled". Document attached. The Home Health Agency provided was from the same insurance company and they should know that the order for wound care was "daily and PRN if soiled". However, the insurance company only covers 3x/wk visits and not daily. Thus, the physician's order for "daily wound care and PRN if soiled" were not met. The administrator recommended to the Public Gurdian that the HMO insurance be dropped because it does not cover daily wound care/daily RN visits. 3. The administrator will ensure that an exemption to retain a resident with pressure ulcer be obtained first before admitting a resident with pressure ulcer and to ensure appropriate care will be provided according to the physician's order. The administrator will not admit a resident with pressure ulcer if the above provisions were not met. 4. The Administrator 5. 12/13/2019, 3-way call among the Public Guardian, the administrator and the Home Health Agency. 12/14/19 R1 admitted to acute care facility.	01/21/2020

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	submit a request for exemption. The facility did submit an exemption waiver request on 11/29/19 as indicated in the Plan of Correction. The waiver request documentation included a signed statement by the Administrator, "I accept the responsibility to ensure the care and needs of this resident will be met by the caregivers of this facility." The waiver request documentation which was submitted included the 11/27/19 physician's orders for daily wound care by a skilled nurse from the Home Health Agency Registered Nurse. The Bureau of Public and Behavioral Health (Bureau) responded to the waiver request on 12/09/19, and indicated the request for exemption failed to include wound care notes, wound stage, wound cause, and documentation that the wound is in a stage of healing from the home health care providing medical oversight. On 12/13/19 at 2:15 PM, upon entry to the facility to investigate the complaint regarding R1's sacral wound, R1 was observed laying on the couch horizontally with non-sensical, garbled speech and moaning. The Caregivers indicated R1 had declined within the past week, was not eating or drinking, the sacral wound had a really bad odor and yellowish-brown discharge, and was moaning in pain, especially when having the brief changed and being repositioned. The Administrator contacted the Public Guardian to communicate R1's deteriorating status. The Public Guardian subsequently directed the Administrator to send R1 to an acute care facility. R1 was admitted to the acute care facility on 12/14/19. The History and Physical report documented R1 had an infected sacral decubitus ulcer with necrotic eschar tissue 7 x 8 centimeters (cm), had sepsis, and dehydrated. The facility admitted and retained a resident with a sacral ulcer and failed to ensure appropriate care was provided to the resident within physician's orders, failed to ensure medical care was provided upon the deterioration of the resident, and failed to notify the			

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	Guardian and the Physician upon the deterioration of the resident, resulting in an infected pressure ulcer, sepsis, and dehydration. Severity: 2 Scope: 1 Repeat Deficiency: 11/12/19			