Division of Public and Behavioral Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 330 | A. BUILDING _____ B. WING _____ | 01/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **FAIRWAY RESIDENTIAL CARE HOME** | **3817 FAIRWAY CIRCLE, LAS VEGAS, NEVADA ,89108** |

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| 0000 | Initial Comments -<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey conducted in your facility on 1/3/19 and completed on 1/4/19. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for residents with Alzheimer's disease, Category II residents. The census at the time of the survey was nine. Nine resident files were reviewed and four employee files were reviewed. The facility received a grade of C. 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 deficiencies were identified: | 0000 | | |

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| 0320 SS= D | 449.220(1) - Bedroom Doors - Locks - NAC 449.220 Bedroom doors. 1. A bedroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure 1 of 4 resident bedrooms had a single motion lock (Bedroom #3). Findings include: On 1/3/19 at 10:30 AM, during the tour, the caregiver was unable to unlock the door leading into bedroom #3. The caregiver had to go get something to insert into the door handle to unlock the door. The handle on the door did not have a single motion lock mechanism. On 1/3/19 at 10:32 AM, the caregiver was not aware a single motion lock was needed on bedroom doors. On 1/3/19 at 10:45 AM, the Administrator looked at the door handle and verified the lock was not a single motion lock. The Administrator explained the door should have a single motion lock and was not aware of when the lock was changed or why the lock was changed. Severity: 2 Scope: 1 | 0320 | Effective 2/7/19, bedroom #3 door handle replaced with a single motion lock mechanism. Administrator has checked facility door handles and replaced with a single motion lock mechanism to ensure compliance. Administrator will be required to be notified of any changes/modifications to the facility structures. Administrator will monitor for compliance. | 02/07/2019 |

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| 0335 SS= D | 449.221(1) - Bedroom Prohibited - NAC 449.221 Use of certain areas in facility as bedroom prohibited. A hall, stairway, unfurnished attic, garage, storage area or shed or other similar area of a residential facility must not be used as a bedroom. Any other room must not be used as a bedroom if it: 1. Can only be reached by passing through a bedroom occupied by another resident.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure a bedroom had a door for 1 of 9 residents. Findings include: On 1/3/19 at 9:30 AM, a bedroom located in the hallway by the side door had a curtain instead of a door. The door way to the room was not the size of a regular door. The resident was in the room lying on the bed and explained the curtain did not bother them. On 1/4/18 at 12:32 PM, the Administrator explained the facility was purchased in 2002 from another group home operator. The facility was licensed for ten residents. The Administrator had always had eight or less residents and did not need the room until now, the facility currently had 9 residents. The Administrator always used the room for storage of old beds and other items. Severity: 2 Scope: 1 | 0335 | Effective 2/16/19, resident relocated to another room of the facility shared with another resident. Room has now been designated as a storage room area. Administrator will ensure the room only use for storage. Administrator will monitor for compliance. | 02/16/2019 |

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| 0531 SS= F | 449.260(1)(f) - Activities for Residents - NAC 449.260 Activities for residents. 1. The caregivers employed by a residential facility shall: (f) Encourage the residents to participate in the activities scheduled pursuant to paragraph (e).<br><br>Inspector Comments: Based on observation, interview and record review, the facility failed to ensure activities on the activity calendar were followed and residents were asked to participate in scheduled activities. Findings include: On 1/3/19 at 9:30 AM, four residents were seated in the living room watching television, three residents were seated at two dining room tables. One resident was playing with napkins, one resident was playing on a computer and one resident was sitting at the dining room table. The facility had an activity calendar on the bulletin board. The activities listed were dominos, morning walks, puzzles, card games, walking, shopping and viewing magazines. On 1/3/19 at 9:45 AM, a resident was lying in bed and explained the caregivers do not ask the resident to participate in activities. The resident participated in reading independently. The resident explained most of the residents were non verbal but the resident would like to participate in activities. On 1/3/19 9:50 AM, a resident was sitting in the bedroom and said the only activity they do was watch television. The resident did not play cards or puzzles and did not know of other activities to participate in. On 1/3/19 at 11:05 AM, the Administrator was unable to locate the cards or puzzles. On 1/3/19 at 11:15 AM, Caregiver #1 explained the cards and dominos were in the caregiver's room so the residents did not lose them. The caregiver provided two sets of dominos but could not produce the cards and explained the cards were destroyed. The caregiver explained the residents had been asked to play games but the residents forgot. Severity: 2 Scope: 3 | 0531 | Effective 2/13/2019. Caregivers were giving instructions to follow the schedule activities for the residents. Administrator to follow up daily on the scheduled activities to ensure residents activities are followed.<br>Administrator will monitor for compliance. | 02/13/2019 |
| 0693 SS= D | 449.2712(2) - Oxygen-Caregiver monitor resident ability - NAC 449.2712 Residents requiring the use of oxygen. 2. The caregivers employed by a residential facility | 0693 | 1/3/2019, resident #2 the two oxygen tanks were secured place inside a plastic bin to prevent from falling.<br>Resident #3 oxygen discontinued due to no | 01/03/2019 |

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| | with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident.<br><br>Inspector Comments: Based on observation, interview and record review, the facility failed to ensure two oxygen tanks were secured in Resident #2's closet and 1 of 9 residents had an order for oxygen (Resident #3). Findings include: Resident #2 Resident #2 was admitted on 11/18/17 with a diagnosis of memory impairment. A physician order dated 11/23/18 documented 2 liters of oxygen at night as needed. On 1/3/19 at 10:35 AM, two oxygen tanks were unsecured in the closet of Resident room #4. A Caregiver verified the room was Resident #2's bedroom. On 1/3/19 at 10:36 AM, a Caregiver could not explain why the tanks were not secured but verified the tanks should have been secured. Resident #3 Resident #3 was admitted on 10/27/18 with a diagnoses of high blood pressure. On 1/3/19 at 10:45 AM, the resident was lying in bed with oxygen. The resident had a concentrator and the flow rate was two liters. The resident explained the oxygen was used at night and when the resident was napping in bed. The resident explained 2 liters was the appropriate amount. The | | physician order. The family was notified and will get a doctor's order on next doctor's appointment. the administrator will check monthly the facility oxygen tanks to ensure proper storage and use. administrator to check new resident's file prior to admission to facility. ensuring all documentations in order, use of oxygen. administrator will monitor for compliance. | |

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| | resident's clinical file lacked documented evidence of a physician order for oxygen. On 1/3/19 at 11:15 AM, the Administrator explained the hospice agency was reminded of the need of a physician order but had not produced one. Severity: 2 Scope: 3 | | | |
| 0920 SS= F | 449.2748(1-2) - Medication Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room.<br><br>Inspector Comments: Based on observation and interview, the facility failed to insure medications were secured. Findings Include: On 1/3/19 at 9:15 AM, one bottle of Famotidine 20 milligrams (mg) and one bottle of Pharbetol 325 mg were located on the kitchen table. On 1/3/19 at 9:20 AM, a Caregiver explained the medications were expired and were in the process to be destroyed. The caregiver had to go to bathroom and left the medications unattended. On 1/3/19 at 10:00 AM, a Caregiver bedroom located across from a resident's room had a bottle of cold medication and one insulin pen located on the side table by the bed. The caregiver room did not have a door; instead, a curtain hung in the doorway for privacy. The medications were not secure and were accessible to the residents. On 1/3/19 at | 0920 | Corrected 2/14/19, administrator provided caregivers in-house training (NAC 449-2748 [1-2]) of medication storage and potential harm to residents. administrator will conduct weekly check and monitor for compliance. | 02/14/2019 |

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| | 10:15 AM, a Caregiver bedroom located off the kitchen had unsecured medications. The caregiver room had a bottle of aspirin, fish oil supplements, prostate supplement, vitamin C, multi vitamins and cough syrup. A tube of A and D ointment was located by the bed on a table. On 1/3/19 at 10:30 AM, Caregiver #1 explained the kitchen doors were usually locked and residents were not able to access the kitchen. The door was unlocked because they were cooking breakfast and attending to residents. The caregiver's room was in process of being organized so the medications were left out. Severity: 2 Scope 3 | | | |

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| 0936 SS= E | 449.2749(1)(e) - Resident file-NRS 441A Tuberculosis - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.<br><br>Inspector Comments: Based on interview and record review, the facility failed to ensure a completed two step tuberculosis (TB) screening was done at the time of admission for 2 of 9 residents (Resident #3 and #7). Findings include: Resident #3 Resident #3 was admitted on 10/27/18. The resident's clinical recorded documented the resident had a completed Quantiferon on 12/14/18 with a negative result. The TB screening was conducted late. Resident #7 Resident #7 (R7) was admitted on 3/7/18. The resident's file documented the resident had a completed two step TB screening on 6/11/18. The TB screening was conducted late. On 1/3/19 at 1:30 PM, the Administrator explained R7's family would take the resident to the physician and the family would not get the TB screening performed. R7 was with a local health agency. The Administrator kept reminding them to perform the TB screening and the nurse would not comply. Severity: 2 Scope: 2 | 0936 | Effective 2/12/19, new residents of the facility will require TB test prior to admission to the facility. Without current TB test or prior TB test (less than one year) will not be admitted to the facility. Administrator will review new residents file prior to admission to the facility to ensure proper documentation. Administrator will monitor for compliance. | 02/12/2019 |
| 0938 SS= F | 449.2749(1)(g)(1) - Resident file - ADL Evaluation Admission - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against | 0938 | Corrected 2/18/19, all residents ADLs were updated. Administrator will review residents file upon admission and the initial ADL is completed prior to admission. Administrator will review residents file every six month and update ADLs, thereafter. Administrator will monitor for compliance. | 02/18/2019 |

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| | unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident.<br><br>Inspector Comments: Based on record review and interview, the facility failed to ensure Activities of Daily Living (ADL) assessments were done initially and not less than once a year for 7 of 9 residents (Resident #2, #3 #5, #7, #8 and #9). Findings include: Resident #2 Resident #2 was admitted on 11/18/17 with a diagnosis of memory impairment. The resident's record lacked documented evidence of an initial ADL assessment conducted at the time of admission. Resident #3 Resident #3 was admitted on 10/27/18 with a diagnoses including high blood pressure and memory impairment. The resident's file documented an initial ADL assessment completed on 12/26/18. The assessment was not conducted at the time of admission. Resident #5 Resident #5 was admitted on 5/10/17 with a diagnosis of dementia. The resident's record documented an initial ADL assessment was completed on 10/27/17. The assessment was not conducted at the time of admission. Resident #7 Resident #7 was admitted on 3/7/18 with a diagnosis of advanced dementia. The resident's file documented an ADL assessment was completed on 12/26/18. The assessment was not conducted at the time of admission. Resident #9 Resident #9 was admitted on 10/5/17 with a diagnosis of dementia. The resident's clinical file documented an initial ADL assessment was completed on 9/20/17. The record lacked documented evidence that a 2018 ADL assessment was completed. On 1/3/19 at 1:30 PM, the Administrator explained the initial ADL assessment was done upon admission and annually. The facility used the physician assessment as the initial ADL assessment and used the facility ADL assessment form to perform the annual ADL assessment. | | | |

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| | The Administrator verified the missing ADL assessments. Severity: 2 Scope: 3 | | | |
| 0991 SS= F | 449.2756(1)(b) - Alzheimer's Fac door alarm - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure the alarms were turned on for two doors leading to the front yard. Findings include: On 1/3/19 at 9:10 AM, upon arrival to the facility the side door leading to the front of the house did not have an alarm sound. The front door that lead to the front of the house did not have an alarm sound when the door was opened. On 1/3/19 at 9:15 AM, the side door was opened a second time and the alarm did not sound. The staff were not in the vicinity of the door. A resident laid on the bed, in the room left of the side door. On 1/3/19 at 9:35 AM, a Caregiver explained the alarms were in working order and were turned off when visitors came to the door. On 1/3/19 at 10:00 AM, a Caregiver explained the alarm on the side door was turned off when staff noticed the surveyor walking up the front drive. Severity: 2 Scope: 3 | 0991 | Corrected 2/18/19, front door alarms were defective and replaced with new alarms. Administrator has instructed caregivers alarm system must not be deactivated or turned off. administrator will monitor for compliance. | 02/18/2019 |