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
	6281	A. BUILDING _____ B. WING _____	01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME, LLC	5858 PALMYRA AVE, LAS VEGAS, Nevada ,89146

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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 01/09/2017. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was nine. Nine resident files were reviewed and six employee files were reviewed. The facility received a grade of D. 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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0072 SS= D	449.196(3)(a-c) - Qualifications of Caregiver-Med Training - NAC 449.196 Qualifications of caregivers. 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.037, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees completed the required annual medication management training (Employee #2). Findings include: Employee #2 was hired on 5/21/14 as Caregiver. The Administrator verified the employee administered medications to residents. - Review of employee records revealed the employee completed the 8-hour annual medication management training on 12/9/15. The employee file lacked documented evidence of an annual training in 2016. - On 1/9/17, in the morning, the Administrator explained the employee stopped giving medications on 12/31/16. The Administrator acknowledged the medication management certification was not renewed in 2016 but continued to administer medications until 12/31/16. Severity: 2 Scope: 1	0072	1. Employee #2 is no longer employed. 2. All employee files will be be reviewed every six months to ensure employees have current annual eight hours of medication training. A personal file checklist will be utilize to determine if recertification are needed (attachment #1 Tag Y 0072). 3. The Administrator will monitor for compliance. 4. January 29, 2017	01/29/2017

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0105 SS= D	449.200(1)(f) - Personnel File - Background Check - NAC 449.200 Staffing requirements; limitations on number of residents; written schedule required for each shift. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 6 employees completed the background check requirements (Employee #2). Findings include: Employee #2 was hired on 5/21/14 as Caregiver. - Review of employee records revealed the employee submitted fingerprints on 5/22/14. The State clearance letter was generated on 6/16/14; however, the employee file lacked documented evidence of FBI clearance. - On 1/9/17 in the morning, the Administrator acknowledged the findings and explained the employee had resigned effective the date of survey. Severity: 2 Scope: 1	0105	1. All future employee will be hire after submitting a complete background check. 2. corrective action will be monitor by ensuring above is will be adhere to without exemption, a duplicate copy will be made and keep in administrator. Administrator will be responsible so dificiency will not occur. 3. Completed Jan. 29, 2017	01/29/2017
0878 SS= E	NAC 449.2742(5)(6) - Medication / OTCs, Supplements, Change Order - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers 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	0878	1. a) Resident#1 received her Metformin 500mg in the evening, the same day of the Annual Survey and was logged in the facility MAR. b) Resident#4 was discharged from the facility on January 13, 2017 (attachment #2 Tag Y878 – Resident Discharged). c) Resident#5 allergy relief 10mg, and Loratadine 10mg listed on the MAR are the same medication now provided by the hospice. Allergy relief was taken away from the medication box. d) Resident#6 omeprazole 20mg, hospice provided a new order Omeprazole 20mg take 1 tablet by mouth twice a day (Attachment #3 Tag Y 878). e) Resident#7 Alprazolam order 0.5mg	01/29/2017

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	administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (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 observation, record review and interview, the facility failed to ensure 3 of 9 residents were administered medications following physician's order (Residents #4, #5 and #6) and 1 of 9 residents had medications onsite (Residents #1). Findings include: Resident #1 was admitted on 8/30/13, with diagnoses including Alzheimer's disease, polyosteoarthritis and lung cancer. - Review of January 2017 Medication Administration Records (MAR) revealed the resident was administered Metformin 500 milligrams (mg), take one tablet by mouth twice a day. The medication bottle was empty. It was dispensed on 12/25/16 with 28 tablets. - On 1/9/17 at 12:40 PM, the Administrator explained the hospice nurse did not refill because the insurance would not cover the cost, but the family agreed to pay for it. The Administrator indicated when the hospice nurse came on 1/3/17, they requested refill for Metformin. The hospice nurse came on 1/9/17 but did not bring Metformin. The Administrator reported they did not receive a doctor's order to discontinue Metformin. The Administrator indicated the hospice nurse was going to request a doctor's order to discontinue Metformin but the family wanted to continue the medication. - On 1/9/17 at 12:40 PM, the Administrator explained their policy is to call for refill one		order now matched with the PRN medication record (Attachment#4 Tag Y878 A & B). The Administrator immediately scheduled an in-house medication training on 1/11/17 about strictly following the physician's orders with regards to the administration of medication to all residents and reporting to the Administrator all new, discontinued and medication changes(Attachment #5 Tag Y 878-in-housetraining). 3. Accomplished the following on: a) 1/9/17 d) 2/9/17 e) 1/9/17 In house Medication Training 1/11/17	

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	week before the medication would run out. Resident #4 was admitted on 12/14/16, with diagnoses including acute chronic anemia, hypertension, chronic kidney disease, congestive heart failure and pelvic fracture (sustained at home prior to admission). - Review of January 2017 MAR listed Tylenol Extra Strength 600 mg, take one tablet by mouth every four hours as needed for pain. - The medication container was labeled as Tylenol Extra Strength 500 mg. - The doctor's order dated 12/20/16 read: "Use Tylenol Extra Strength 600 mg, one tablet as needed every four hours for mild pain." - On 1/9/17 at 1:35 PM, the Administrator explained the family brought the Tylenol and they did not notice it was 500 mg. - The January 2017 MAR included Vitamin D3 1000 IU, one tablet by mouth every day (12:00). The last dose was on 1/8/17. - On 1/9/17 at 1:45 PM, the medication was not found in resident's tray. The Administrator explained the family will deliver that afternoon on survey date. At 2:35 PM, the Administrator found Vitamin D3 1000 IU behind other trays not in Resident #4's tray. The resident missed the 1/9/17 dose. Resident #5 was admitted on 4/20/15, with diagnoses including congestive heart failure, atrial fibrillation, malaise, hypertension, depression, anemia and left hip pain. - On 1/9/17 at 2:00 PM, it was observed a medication in resident's tray was labeled Allergy Relief 10 mg, take one tablet by mouth once daily. - The January 2017 MAR did not include Allergy Relief 10 mg. The resident's file lacked documented evidence of a doctor's order. - On 1/9/17 at 2:00 PM, the Administrator explained "the family provided it because it works." Resident #6 was admitted on 6/10/16, with diagnoses including bladder tumor, sepsis, chronic kidney disease, dementia and hypertension. - Review of January 2017 MAR revealed from 1/1/17 to 1/3/17 the resident was administered Omeprazole 40 mg, one capsule by mouth once daily before meals. The resident received this medication at 7:30 AM. However, on 1/4/17, the MAR documented the resident was administered Omeprazole 40 mg at 7:30 AM and Omeprazole 20 mg at 5:00 PM. - On 1/9/17 at 2:15 PM, Omeprazole 20 mg, one			

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	capsule by mouth twice a day was found in resident's medication tray. - The resident file lacked documented evidence of a change order from 40 mg once daily to 20 mg twice a day. - On 1/9/17 at 2:15 PM, the Administrator acknowledged on 1/4/17, they gave the resident a total of 60 mg of Omeprazole. - On 1/9/17 at 2:20 PM, the Administrator called the hospice nurse and requested a doctor's order for Omeprazole 20 mg one capsule twice a day. On 1/9/17 at 2:25 PM the hospice nurse faxed a Physician's Telephone Order that read: "Start 1/5/17 Omeprazole 20 mg, one tablet by mouth every AM." On 1/9/17 at 2:30 PM, the Administrator reminded the hospice nurse the medication container was labeled Omeprazole 20 mg, one capsule twice a day. On 1/9/17 at 3:00 PM, the hospice nurse faxed an amended Physician's Telephone Order that read: "On 1/4/17, Omeprazole 40 mg in AM and 20 mg in PM due to severe indigestion," and included a new order that read: "Change on 1/5/17 to Omeprazole 20 mg, one tablet by mouth every AM and PM." - On 1/9/17 at 3:05 PM, when asked how many days the facility has to obtain a copy of doctor's written order, the Administrator responded one week. The Administrator was reminded they have five days to obtain a doctor's written order, and to make sure to keep them in resident files. Severity: 2 Scope: 2			
0895 SS= E	449.2744(1)(b 1-4)+449.2746(2) - Medication / MAR-PRN MAR - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician. NAC 449.2746 (Refer to NAC 449.2742(5)	0895	1. Resident #3 acetaminophen 500mg take one tablet by mouth every 6 hour as needed for mild to moderate pain. do not exceed 300mg per 24 hours is discontinued, now the new order was obtained acetaminophen 500mg take 1 tablet by mouth every 6 hours for pain (not to exceed 3000mg per 24 hours). (attachment # 6 Tag Y 895 A & B). 2. resident #4 was discharged from the facility on Jan. 13, 2017. 3. the facility MAR was changed to conform with the physician order and label for resident #3, 6 & 7. 4. medication prescription ordered by physician, pharmacy label, frequency & MAR will be check regularly as much as possible to	01/29/2017

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	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.) 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician. Inspector Comments: Based on record review, observation and interview, the facility failed to ensure the Medication Administration Records (MAR) for 4 of 9 residents were accurate (Residents #3, #4, #6 and #7). Findings include: Resident #3 was admitted on 10/4/16. - Review of January 2017 MAR listed Acetaminophen 500 milligrams (mg), give one tablet by mouth every six hours as needed for pain. - The medication container was labeled Pain Relief 500 mg, take one tablet by mouth every six hours as needed for mild to moderate pain. Do not exceed 3,000 mg per 24 hours. - The resident file lacked a doctor's order for Acetaminophen or Pain Relief 500 mg. Resident #4 was admitted on 12/14/16. - Review of January 2017 MAR listed Digoxin 1.25 mg, take one tablet by mouth daily. - The medication container was labeled Digoxin 0.125 mg, one tablet by mouth once daily. - The physician's order dated 12/13/16 read: "Digoxin 125 mcg take one tablet by mouth daily, #30 for atrial fibrillation. On 1/9/17 at 1:50 PM, the Administrator hand wrote the correct medication strength on MAR. Resident #6 was admitted on 6/10/16. - Review of January 2017 MAR listed Levothyroxine 50 mg, take one tablet by mouth every day. - The medication container was labeled Levothyroxine 50 mcg, take one tablet by mouth once daily. - On 1/9/17, the resident file lacked a doctor's order to verify the medication strength. Resident #7 was admitted on 6/10/16. - Review of January		ensure that it will exactly match. 5. the adminstrator will be responsible for compliance. 6. Janaury 29, 2017.	

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	2017 MAR listed Alprazolam 0.5 mg, take one tablet by mouth every 8 hours as needed for anxiety/agitation. - The medication container was labeled Alprazolam 0.5 mg, take one tablet by mouth every 12 hours as needed for anxiety. - The doctor's order dated 12/2/16 read: "Alprazolam 0.5 mg, take one tablet by mouth every 12 hours as needed for anxiety." - On 1/9/17, in the afternoon, the Administrator acknowledged the findings. Severity: 2 Scope: 2			
0905 SS= D	449.2746(1)(a)-(c) - PRN Medication - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. 1. A caregiver employed by a residential facility shall not assist a resident in the administration of medication that is taken as needed unless: (a) The resident is able to determine his need for the medication. (b) The determination of the resident's need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure the "as needed" medication for 1 of 9 residents included specific instructions for administration (Resident #2). Findings include: Resident #2 was admitted on 3/20/14, with diagnoses including, Alzheimer's disease, dementia, anxiety, bipolar disorder, arthritis, osteopenia and visual impairment. - Review of January 2016 Medication Administration Records (MAR) listed Hydrocodone/Acetaminophen 5-326 milligrams (mg), take one tablet by mouth every 4-6 hours as needed for toothache. The medication container was labeled Hydrocodone/APAP 5-325 mg, take one tablet by mouth every 4-6 hours as needed. The physician's order dated 12/8/16 read: Norco 5/325 mg #20, take one tablet by	0905	1. administrator will ask physician when prescribing medication to resident to give specific instruction on the frequency of administration of mediccation, specify reason or symptoms for giving such medication. 2. the administrator obtained a discontinue order from the physician on hydrocodone (norco) and ibuprofen (motrin) on Jan. 10, 2017 (attachment #7 Tag Y 905). 3. administrator is responsible for implementing plan of correction. 4. corrective action completed Jan. 29, 2017.	01/29/2017

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	mouth every 4-6 hours as needed. - The MAR also included Ibuprofen 800 mg, take one tablet by mouth every 6-8 hours as needed for pain. The medication container was labeled Ibuprofen 800 mg, take one tablet by mouth every 6-8 hours as needed for pain/toothache. The physician's order read Motrin 800 mg, one tablet every 6-8 hours. For both Hydrocodone/Acetaminophen and Ibuprofen, the frequency of administration was not specific and relied on the caregiver's decision as to when it could be administered. The symptom or reason for which the medication was to be administered was not specified on the doctor's order and were not consistent with the pharmacy label and MAR. - On 1/9/17 at 1:10 PM, the Administrator explained on 12/8/16, the resident had a dental procedure; the prescriptions came from their dentist. The Administrator indicated they will ask the dentist to discontinue these medications because the resident did not have pain. Severity: 2 Scope: 1			

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0923 SS= D	449.2748(3)(a-b) - Medication Container - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 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. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure over-the-counter medications for 2 of 9 residents were labeled (Residents #2 and #4). Findings include: Resident #2 was admitted on 3/20/14. - Review of January 2017 Medication Administration Record (MAR) revealed the resident was administered Calcium 600 milligrams (mg) +Vitamin D3, take one tablet by mouth once a day. - On 1/9/17 at 1:05 PM, a bottle of Calcium 600 mg + Vitamin D3 was in Resident #2's tray; however, it was not labeled with the resident's and physician's names. - On 1/9/17 at 1:05 PM, the Administrator acknowledge the findings and wrote the names of resident and physician while the survey was in progress. Resident #4 was admitted on 12/14/16. - Review of January 2017 MAR listed Milk of Magnesia take 30 ml by mouth daily as needed if no bowel movement for three days. - On 1/9/17 at 1:50 PM, it was observed the Milk of Magnesia bottle in resident's tray was not labeled with resident's and physician's names. - On 1/9/17 at 1:53 PM, the Administrator placed a label on the Milk of Magnesia bottle while the survey was in progress. Severity: 2 Scope: 1	0923	1. The Administrator made sure that all OTC (over the counter) medications and dietary supplements are plainly labeled as to its content, name of the resident, prescribed for, name of doctor, frequency and kept in its original container until used. 2. The Administrator will give specific instruction to all caregivers to make sure that above procedure is followed for all resident without any exceptions.The Administrator will review all resident prescription containers weekly to monitor that is in compliance with HCQC regulations. Administrator will be responsible and will ensure deficiency will not re-occur. 3. Accomplished 1-11-2017	01/29/2017

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0930 SS= F	449.2749(1)(a) - Resident File-Storage, Res Information - 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: (a) The full name, address, date of birth and social security number of the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure resident records were secured. Findings include: - On 1/9/17 at 10:15 AM, it was observed, a binder with residents' medication receipts were stored on an open shelving unit near the dining table. The binder was overflowing with unfiled medication receipts. Some of the receipts were from May 2016. - On 1/9/17 at 10:15 AM, the Administrator explained they were in the process of sorting and filing the receipts. - On 1/9/17 at 10:20 AM, it was observed four binders used by home health/hospice nurses were stored on top of a filing cabinet unsecured. - On 1/9/17 at 10:20 AM, the Administrator acknowledged the findings and informed the employee the binders will be locked in the filing cabinet from that day onward. Severity: 2 Scope: 3	0930	1. All Resident files, home health and hospice nurses binders will be returned and locked in the filing cabinet at all times. 2. This policy was reiterated on 1/9/17 by the administrator of the facility. The Administrator and lead caregiver will have the keys in their person at all times for the residents filing cabinet and ensure that it's locked. 3. Accomplished on 1/9/17.	01/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6281	A. BUILDING _____ B. WING _____	01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0990 SS= F	449.2756(1)(a) - Alzheimer's facility pools - NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (a) Swimming pools and other bodies of water are fenced or protected by other acceptable means. Inspector Comments: Based on observation and interview, the facility failed to ensure the pool gate was locked. Findings include: - On 1/9/17 at 3:05 PM, during an inspection of the exterior premises, it was observed the door to the inground pool was not secured. The door latch had a padlock inserted but the padlock was not pushed down to locking position. - On 1/9/17 at 3:05 PM, the Administrator explained the pool serviceman came the day before and immediately locked the gate. Severity: 2 Scope: 3	0990	1. The Administrator immediately instructed the caregiver to check and make sure the pool gate is secure and locked. 2. The Administrator instructed all caregivers to check and lock the pool gate every after pool service and kept locked at all times. A "KEEP GATE LOCKED" sign is placed by gate (attachment #8 tag Y 990) 3. Accomplished on 1/29/17.	01/29/2017
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. Inspector Comments: Based on observation and interview, the facility failed to ensure the front door had audible alarm that was operational. Findings include: - On 1/9/17 at 9:20 AM, when Employee #4 opened the front door, it was observed the alarm did not sound off. At 9:50 AM, when the Administrator entered the facility, the front door alarm did not sound off. After the employees were notified, they checked the alarm and determined it was not functioning. - On 1/9/17 at 9:20 AM, the Administrator explained the batteries were just changed the weekend prior. The front door alarm was operational after the facility changed the batteries while the survey was in progress. Severity: 2 Scope: 3	0991	1. The Administrator immediately had the battery for the Front door alarm replaced during Annual Survey and ensure that it was operational. 2. The Administrator instructed all caregiver to continuously monitor the Front door alarm, particularly upon entry and exit from the facility for alarm activation. Battery supply were purchased as precautionary measure incase of another alarm failure. 3. Administrator is responsible for enforcing deficiency. 4. Accomplished on 1/09/17	01/09/2017