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
	7543	A. BUILDING _____ B. WING _____	01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE RESIDENTIAL HOME	**5559 TROOPER STREET, LAS VEGAS, NEVADA ,89120**

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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 1/11/18. 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 9. The facility received a grade of A. 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:	0000		

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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 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. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 1/11/18 at 9:00 AM, during a tour of the facility an oxygen tank was unsecured located in the back hallway behind the kitchen. On 1/11/18, the Administrator was unaware the oxygen tank should have been secured. Severity: 2 Scope: 1	0693	Administrator had immediately placed oxygen tanks in a secured location, and ensured that extra bottle of Oxygen is no longer a risk. Administrator understood the risks, but didn't realize that staff put the Oxygen tank there. Administrator held a staff meeting on 1/18/18 where proper storage of oxygen tanks was discussed. Administrator posted a few flyers at Angel Care, to remind staff on this procedure. (Attached.) Administrator will be doing weekly spot checks to ensure that Oxygen tanks are secured in the home. Please see attached Staff meeting Agenda.	01/27/2018
0878 SS= D	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	0878	PRN medications were recently audited and these were ordered from Pharmacy. Administrator ensured that they were delivered on 1/11/18. Administrator held a training on 1/18/18 with staff, discussing need to follow up with	01/27/2018

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	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 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 record review and interview, the facility failed to ensure 2 of 9 residents medications were available and on site as prescribed by a physician (Resident #2 and #9). Findings include: On 1/11/18 at 11:30 AM, review of medications revealed Resident #2 was prescribed Milk of Magnesia 400/5 milliliters (ml). Take 30 ml by mouth everyday as needed for constipation. The medication was not on site. On 1/11/18 at 11:30 AM, Resident #9 was prescribed Milk of Magnesia 400/5 milliliters (ml). Take 30 ml by mouth everyday as needed for constipation. The medication was not on site. On 1/11/18 at 11:30 AM, Caregiver #3 indicated the Milk of Magnesia for Resident		Pharmacy if medications are not delivered the day they were ordered. As these medications expired, it was necessary to re-order, but staff needed to follow up on delivery order. Administrator will ensure that weekly spot checks are conducted on rarely used PRN medications to ensure that they are always available as needed and prescribed.	

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	#2 and Resident #9 was not on site. Severity: 2 Scope: 1			
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 and interview, the facility failed to ensure 1 of 9 residents as needed medications did not require caregiver assessment (Resident #1). Findings Include: On 1/11/18 at 11:00 AM, review of mediations revealed Resident #1 was prescribed Mapap 325 milligrams. Take one tablet by mouth three times a day as needed for pain/fever. On 1/11/18 at 11:00 AM, Caregiver #3 verbalized Resident #1 was not able to make her needs known. The Caregiver acknowledged the physician should have documented when to administer the medication for a fever. Severity: 2 Scope: 1	0905	It is important to have proper documentation of prescriptions, and Administrator had contacted Resident#1's primary care team to correct prescription and provide exact measurements of the level of fever, when prescribed medication should be given to Resident #1. Administrator will ensure that all PRN medications are scripted precisely.	02/21/2018

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0936 SS= D	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. Inspector Comments: Based on record review, the facility failed to ensure 1 of 9 residents met the requirements concerning tuberculosis (TB) testing (Resident #3). Findings Include: Resident #3 was admitted to the facility on 2/9/17. On 1/11/2018 at 10:30 AM, review of Resident #3 medical record revealed a one step TB test was completed on 2/10/17. The file lack documented evidence a second step was completed. On 1/11/2018 at 10:30 AM, the Administrator was unable to provide the second step TB test for Resident #3. Severity: 2 Scope: 1	0936	Administrator will use attached document when admitting new residents to ensure that she follows all TB requirements. Administrator will ensure that all new admittances have the two step TB or equivalent required TB test in place prior to admission. Resident #3 had an appointment on January 30, 2018 at 8 a.m. at Quest to complete this task, however, that Quest location didn't allow the Quantiferon Test. So, Resident #3 was taken to another Quest on 2/5/18 and completed the Quantiferon test.	02/21/2018