

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8156	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2023
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NAME OF PROVIDER OR SUPPLIER HOLY ANGEL CARE HOME I	STREET ADDRESS, CITY, STATE, ZIP CODE 1517 GENTLE BROOK STREET, N. LAS VEGAS, NEVADA ,89084
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(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	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 04/20/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was 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 survey was four. Four resident files and four employee files were reviewed. The facility received a grade of B. 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.</p>	0000		
0895 SS= E	<p>Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications 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.</p> <p>Inspector Comments: Based on observation, interview and document review, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 4 sampled residents (Resident #3 and Resident #4). Findings include: Resident #3 (R3) R3 was admitted on 12/01/18 with diagnoses including dementia and hypertension. R3's April 2023</p>	0895	<p>This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct)on the community. It is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. The facility desires that this plan of correction be considered the facilities recognition of compliance.</p> <p>1) The MAR was corrected with the correct medication instructions for the Acetaminophen 500 mg to match the script for resident #3. 2)When completing the MAR monthly. The team will triple check the MAR with the script, and the medication bottle to ensure that the medication and instructions are correct. 3) Monthly the MAR will be reviewed by the Owner and or Administrator 4) Administrator is responsible 5) 5/8/23</p>	05/08/2023

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: TRINA M ANDERSON Title: Administrator

Date: 05/11/2023

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	<p>MAR documented to give Acetaminophen 325 milligrams (mg) tablets, take 2 tablets by mouth every four hours as needed (PRN) for pain. The label on R3's medication bottle documented Acetaminophen 500 mg tablets, take 1 tablet by mouth every six hours PRN for pain. On 04/20/23 in the morning, a Caregiver acknowledged the current physician's order was the same as what was documented on the medication bottle and R3's MAR was inaccurate. Resident #4 (R4) R4 was admitted on 06/02/14 with diagnoses including dementia and hypertension. R4's April 2023 MAR documented to give Carvedilol 6.25 mg tablets, take 1 tablet by mouth daily. The label on R4's medication bottle documented Carvedilol 6.25 mg tablets, take 1 tablet by mouth twice a day. On 04/20/23 in the morning, a Caregiver acknowledged the current physician's order was the same as what was documented on the medication bottle and R4's MAR was inaccurate. On 04/20/23 in the morning, a Caregiver acknowledged R3's and R4's MAR should have the same documentation as the physician's order and the label on the medication bottle. Severity: 2 Scope: 2 This was a repeat deficiency from the 04/26/22 survey.</p>			

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0991 SS= F	<p>Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 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.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure an alarm system was audible and functioning on one door exiting the facility. Finding include: On 04/20/23 at 9:00 AM, the alarm system on the front door was not audible and functioning. On 04/20/23 at 11:00 AM, a Caregiver acknowledged the alarm on the front door was not audible and functioning. The Caregiver indicated the alarm on the front door should have been audible and functioning. Severity: 2 Scope: 3 This was a repeat deficiency from the 04/26/22 survey.</p>	0991	<p>1) The door alarm was replaced with a new alarm. 2) The team will notify the administrator or owner when the door alarm is not working immediately. 3) Daily check of the door alarm will be required by the care team. 4) Administrator is responsible 5) 5/8/23</p>	05/08/2023

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0994 SS= F	<p>Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure sharp objects were not accessible to residents. Findings include: On 04/20/23 at 9:00 AM, located in the backyard next to the patio area was a chainsaw and a gas powered tree trimmer accessible to residents. On 04/20/2023 at 11:00 AM, a Caregiver acknowledged the chainsaw and gas powered tree trimmer were accessible to residents and should have been stored in a locked area for resident safety. Severity: 2 Scope: 3</p>	0994	<p>1) Landscaper removed items when done trimming trees and doing the landscaping. Residents were inside while the landscaper was there. 2) Landscaper will take the items with them when they go to the front or to the garage to get items. 3) A sign has been posted at the back to remind the landscaper to not leave any sharp items or dangerous items. 4) Administrator is responsible 5) 5/09/23</p>	05/09/2023
0999 SS= F	<p>Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility.</p> <p>Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 04/20/23 at 9:00 AM, located in the backyard next to the patio area was a canister of gasoline and a spray canister of weed killer accessible to residents. On 04/20/2023 at 11:00 AM, a Caregiver acknowledged the canister of gasoline and a spray canister of weed killer were accessible to residents and should have been stored in a locked area for resident safety. Severity: 2 Scope: 3 This was a repeat deficiency from the 04/26/22 survey.</p>	0999	<p>1) Landscaper removed items when done trimming trees and spraying the weeds. Residents were inside while the landscaper was there. 2) Landscaper will take the items with them when they go to the front or to the garage to get items. 3) A sign has been posted at the back to remind the landscaper to not leave any sharp items or dangerous items. 4) Administrator is responsible 5) 5/09/23</p>	05/09/2023