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
	6087	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SHARE CARE HOME NEVADA, INC	7925 W ROSADA WAY, LAS VEGAS, NEVADA ,89149

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of the Annual Grading Survey conducted at your facility on 11/20/19 through 11/21/19, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds to provide care for elderly or disabled persons with endorsements for persons with mental illness and chronic illness. The census at the time of the survey was eight. Eight resident records and six employee records were reviewed. 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		
0743 SS= D	Residents Requiring Indwelling Catheter - NAC 449.272 Residents requiring use of indwelling catheter. (NRS 449.0302) 2. The caregivers employed by a residential facility with a resident who requires the use of an indwelling catheter shall ensure that: (a) The bag and tubing of the catheter are changed by: (1) The resident, with or without the assistance of a caregiver; or (2) A medical professional who has been trained to provide that care; (b) Waste from the use of the catheter is disposed of properly; (c) Privacy is afforded to the resident while care is being provided; and (d) The bag of the catheter is emptied by a caregiver who has received instruction in the handling of such waste and the signs and symptoms of urinary tract infections and dehydration. Inspector Comments: Based on interview and record review, the facility failed to ensure the catheter care was provided by a skilled nurse per physician's instructions for one of eight residents (Resident #5 - suprapubic catheter). Severity: 2 Scope: 1	0743	A.) Administrator and facility staff immediately contacted Resident #5 medical provider to request Home Health Services. Home Health was obtained to provide skilled nursing services including catheter care. Home Health visits once a week and changes catheter bag every 3 weeks or as needed. Home Health is available 24/7 for residents skilled nursing needs. B.) Administrator will ensure Home Health Services is in place for residents requiring skilled nursing services. C.) Complete Date: 11/25/2019 02/12/2020 D.) See Attached TAG 0743	02/12/2020
0785	Diabetes - Written Plan of Care - NAC	0785	A.) Administrator and facility staff	01/22/202

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SS= D	449.2726 (as amended by LCB File No. R109-18) Residents having diabetes 2. A caregiver employed by a residential facility may assist a resident in the administration of the medication prescribed to the resident for his or her diabetes if: (c) A written plan of care by a physician or registered nurse has been established that: (1) Addresses possession and assistance in the administration of the medication for the resident's diabetes; and (2) Includes a plan, which has been prepared under the supervision of a registered nurse or licensed pharmacist, for emergency intervention if an adverse condition results. Inspector Comments: Based on interview and record review, the facility failed to ensure a written plan of care for diabetes management was maintained for one of eight residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 01/06/16 with diagnoses including diabetes mellitus I and hyperlipidemia. R1 was insulin-dependent. There was no plan of care written by a Physician or Registered Nurse for emergency intervention if an adverse condition results (i.e., critically low or critically high blood glucose levels). Review of the blood sugar readings documented the following critically low / out of range readings: 05/31/19: Dinner: 50 06/03/19: Breakfast: 49 06/04/19: Dinner: 53 06/08/19: Dinner: 59 06/09/19: Lunch: 59 06/13/19: Bedtime: 59 06/16/19: Dinner: 39 06/18/19: Lunch: 56 06/24/19: Dinner: 47 06/25/19: Dinner: 51 07/17/19: Dinner: 54 08/06/19: Dinner: 59 08/29/19: Bedtime: 48 09/04/19: Dinner: 50 09/05/19: Dinner: 49 09/06/19: Bedtime: 44 10/05/19: Bedtime: 38 10/07/19: Dinner: 45 10/08/19: Bedtime: 48 11/02/19: Breakfast: 52 11/11/19: Dinner: 53 11/12/19: Dinner: 53 11/16/19: Dinner: 57 11/20/19: Breakfast: 52 On 11/20/19 at 2:00 PM, the Caregiver indicated if the blood sugar was really low she would give R1 some orange juice and a peanut butter sandwich. The Caregiver indicated she did not re-test R1's blood sugar until the next scheduled mealtime. The Caregiver indicated she was not instructed by a medical professional how		immediately contacted the Veterans Affairs Clinic to schedule an appointment for Resident #1 to request for a Plan Of Care for his diabetes management. Feb 4, 2020 is the earliest available scheduled appointment with Endocrinologist for Plan of Care for Diabetes Management. On Feb 4, 2020 Resident attended a 60 min education DM management consultation and obtain a new Endocrinology provider to manage DM. B.) Administrator shall inform facility staffs the Plan of Care /Diabetes Management (written by a Physician or a Register Nurse) for diabetic residents must be provided and maintained in residents file. C.) Complete Date : 01/22/2020 02/04/2020 D.) See Attached : TAG 0785	0

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	much orange juice to give and to re-test the blood sugar. The Manager and the Caregiver indicated they did not notify R1's physician of the critically low blood sugar readings and did not seek medical attention. Communication to the Physician (Physician #1) dated 06/21/19 documented the Manager sent the following FAX: "...Pt (patient) has been exhibiting unusual behavior / symptoms. Like fatigue and confusion / disoriented. (R1's) blood sugar level was at 7:00 AM was 349, 8:45 AM 332, 10:59 AM 302, 11:32 AM 278, 4:03 PM 268. (R1) is taking (R1's) meds (medications) and Insulin on time. But whenever (R1) takes the Insulin (R1) would stare at it for some time like (R1) does not know what to do with it. We called your office, but said you close at 4 PM. Please advise." On 11/20/19 at 3:45 PM, the Manager verified he sent the FAX communication to the Physician on 06/21/19 but the facility did not receive a response. The Manager indicated Physician #1, who was an Endocrinologist, had retired, and the resident did not have a new Endocrinologist to provide care, who the facility could communicate with. The Manager verified there was no Home Health Registered Nurse or Medical Professional assigned. Severity: 2 Scope: 1			

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0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver 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 administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (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 interview and record review, the facility failed to ensure there were current physician's orders for Coumadin for 1 of 8 residents (Resident #7). Severity: 2 Scope: 1	0878	A.) Prior to inspection, Administrator and facility staffs have already been in communication with medical provider requesting for current orders/directives. POA/Brother was also informed as he is the person managing Resident's INR. On 01/20/20 Facility Received current order/ directives of said medication. See Attached B.) Administrator and facility staff shall monitor Residents #7 INR and current medication orders on file. C.) Complete Date : 01/20/2020 D.) Attached: Tag 0878	01/20/2020

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0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her 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 interview and record review, the facility failed to ensure there were specific written instructions for the area for topical medication to be administered to one of eight residents (Resident #5: Ammonium Lactate topical and Diflonec Sodium). Severity: 2 Scope: 1	0905	A.) Administrator and staff requested Resident #5 Physician for a specific written instructions on said medication. Received a DISCONTINUE order from provider. B.) Administrator shall ensure Physicians orders of medications are specifically written in order to be administered to residents. C.) Complete Date : 01/08/2020 D.) See Attached : TAG 0905	01/08/2020