DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295077		R-C 07/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(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
{F 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a revisit survey conducted at your facility on 7/16/07. The revisit was conducted to ensure compliance with the survey findings of a complaint investigation conducted on 5/16/07. (Complaint #NV00014971) The findings and conclusions of any investigation by the Health Division 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:	{F 000}	RECEIVED JUL 25 2007 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA *Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law.*	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and resident interview, it was determined that the facility failed to follow physician orders, care plan, and facility policy for 1 of 4 residents. (Resident #2) Findings include: Resident #2: The resident was admitted to the	F 309	**F 309** The facility will provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being. **What corrective Action will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 2. Resident's MD revised the Milk of Magnesia (MOM) order to be given PRN for no bowel movement with abdominal distention and/or as specifically requested by Resident. Resident's plan of care also updated to reflect her current condition (including refusal to take her MOM).	7-25-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] — Administrator — 07-23-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295077		R-C 07/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(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
F 309	Continued From page 1 facility on 11/09/06, with diagnoses including pneumonia, urinary tract infection, chronic obstructive airway disease, dysphagia, blindness, constipation, osteoarthritis, esophogeal reflux, macular degeneration, hypothyroidism, acute respiratory failure, and muscle disuse atrophy. The admitting orders included an order for Milk of Magnesia 30 cc (cubic centimeters) by mouth every third day if no bowel movement as needed for constipation. Review of the facility's "Bowel Monitoring Policy" revealed that "Bowel movements will be monitored daily to assure that each resident will receive prompt therapeutic intervention(s) when needed to prevent complications of constipation." The policy also revealed a "BM protocol" that read "give 30 cc by mouth of Milk of Magnesia every third day if no bowel movement (by PM nurse)." It further read that the "bowel protocol will be followed for residents with no documented bowel movement times three days." This was revealed to have been tracked through the use of a "Laxative List," which is a document that the facility used to track which residents have not had a bowel movement for three days or greater to prompt the nurses to administer a laxative. A review of the Activities of Daily Living (ADL) Record for June of 2007, revealed that Resident #2 had no bowel movement documented from 6/19/07 through 6/24/07. A review of the laxative list dated 6/20/07, revealed that the resident had been identified as having had no bowel movement for three days. The resident was also was identified on the laxative list dated 6/23/07, as having had no bowel movement for six days. Review of the medication administration record (MAR) revealed no administration of the Milk of	F 309	**How you will identify other resident having the potential to be affected by the same practice and what anticipated corrective action will be taken:** All residents have the potential to be affected by the practice. Nurses in-serviced on Facility's Bowel Protocol, accurate documentation and assessment of residents with no bowel movement. Please refer to "Attachment A". **What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Another in-service meeting scheduled on July 23, 2007 and will be ongoing. A copy of the Laxative List will be submitted daily to the DON and/or designee for review to ensure Bowel Protocol is followed consistently. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:** DON and/or designee will conduct regular medical record audit focusing on adherence to Facility's Bowel Protocol to ensure follow through by Nursing Staff. As necessary, Resident will be referred to IDT for review and possible update of care plan. **Individual Responsible:** Director of Nursing **Date of Completion** July 25, 2007	7-25-07

RECEIVED
JUL 25 2007
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295077		R-C 07/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(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
F 309	Continued From page 2 Magnesia as ordered during the month of June. Review of the nurses' notes revealed no documentation related to the omission of the Milk of Magnesia administration as ordered or the assessment of the resident's bowel status. Review of the ADL Record for July of 2007 revealed that Resident #2 had no bowel movement documented from 7/4/07 through 7/8/07. Review of the laxative list dated 7/7/07, revealed that the resident had been identified as having had no bowel movement for three days. The resident was also was identified on the laxative list dated 7/8/07, as having had no bowel movement for four days. Review of the MAR revealed no administration of the Milk of Magnesia as ordered for the month of July. Review of the nurses' notes revealed no documentation related to the omission of administration of the Milk of Magnesia as ordered, or the assessment of the resident's bowel status. Review of the care plan for Resident #2 revealed a goal of "resident will have regular bowel elimination at least every three days." Interventions included "administration of Milk of Magnesia as ordered, observe for abdominal distention/pain, auscultate bowel sounds or perform digital exam if indicated." On 7/16/07 at 10:35 AM, the Director of Nursing (DON) was interviewed. She stated that if a resident had no bowel movement for three days night shift would identify them and place them on the laxative list. This list would then be reviewed by the oncoming day shift nurse, and the ordered medication would be administered during the evening medication pass on the day identified.	F 309	PLEASE SEE P. 1 & 2 OF 4	7-25-07

RECEIVED
JUL 25 2007
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	295077		R-C 07/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(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
F 309	Continued From page 3 She also stated that Resident #2 often refused to take a laxative when offered as her normal pattern was to have a bowel movement once weekly and did not believe that the Milk of Magnesia had been given. She also stated that it should be documented that the resident refused the medication on the medication administration record and the nurse should be assessing the resident's abdomen. On 7/16/07 at 11:20 AM, the medication nurse was interviewed. She stated that she did not feel that the resident's normal pattern was to have a bowel movement weekly. She further stated that the resident had not refused a laxative for her, although she stated that she had been told that the resident had refused to take laxatives from other nurses. She stated that the nurse would document on the MAR if the Milk of Magnesia had been given or if the resident had refused to take the medication. On 7/16/07 at 11:35 AM, Resident #2 was interviewed. The resident stated that her normal pattern was to have a bowel movement "every other day or so." She stated that she could not remember the dates in question. She also could not remember refusing to take Milk of Magnesia at any time.	F 309	PLEASE SEE P. 1 & 2 OF 4	07-25-07

RECEIVED
JUL 3 0
BUREAU OF LICENSURE
AND CERTIFICATION
CARSON CITY, NEVADA