Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	NVN438AGC		07/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAGONEER GROUP CARE	3705 WAGONEER DR RENO, NV 89502

(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) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 7/29/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons, Category I residents. Four resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 152 SS=A	449.204(2) Insurance-BLC endorsement NAC 449.204 2. A certificate of insurance must be furnished to the Division as evidence that the contract required by subsection 1 is in force and a license must not be issued until that certificate is furnished. Each contract of insurance must contain an endorsement providing for a notice of 30 days to the bureau before the effective date of a cancellation or nonrenewal of the policy. This Regulation is not met as evidenced by: Based on interview on 7/29/08, the facility did not have evidence of a current certificate of insurance. Findings include: The administrator was unable to provide evidence of a current certificate of insurance for	Y 152		

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

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 152	Continued From page 1 verification it met the requirements. Severity: 1 Scope: 1	Y 152		
Y 178 SS=E	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by: Based on observation and interview on 7/29/08, the facility did not ensure all grab bars and handrails were secure for use by residents. Findings include: 1. A full bathroom was located in the main hallway of the facility. The handrail installed on the south inner wall of the shower was not secured to the wall behind the fiberglass enclosure. The bar pulled away from the wall when pressure was applied to it. The caregiver stated residents were typically showered in another bathroom and this bathroom was mainly used by caregivers, but the bathroom was located closer to the living areas of the facility. 2. There was access to the backyard through a sliding glass door in the small living area east of the kitchen. A wooden ramp with a wood handrail was located outside the door for residents to use. The handrail wobbled and was not secured to the wooden ramp.	Y 178		

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Y 178	Continued From page 2 Severity: 2 Scope: 2	Y 178		
Y 272 SS=C	449.2175(3) Service of Food - Menus NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. This Regulation is not met as evidenced by: Based upon observation, record review and interview on 7/29/08, menus had not been kept on file for 90 days and substitutions were not noted on the written menus. Findings include: During the facility tour, it was noted that the weekly menu was not posted. An interview with Employee #2 revealed the staff did not post the menus, record substitutions on the menus nor keep their menus for 90 days. The folder with the facility's menus lacked evidence of the menus being kept on file for 90 days and any substitutions recorded on the planned menus. Severity: 1 Scope: 3	Y 272		
Y 883 SS=D	449.2742(7) Medication / Resident Refusal NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.	Y 883		

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Y 883	Continued From page 3	Y 883		
	This Regulation is not met as evidenced by: Based on record review and interview on 7/29/08, the facility did not ensure a resident's physician was called when 1 of 4 residents missed a medication. Findings include: Resident #1 was prescribed Sensipar 30 mg tablet once daily. The resident's July 2008 medication administration record (MAR) indicated the resident was not given the medication on 7/7/08 and 7/8/08. The caregiver documented the refill of the resident's medication was not delivered timely by the pharmacy, so they ran out of the medication. There was no evidence the resident's physician was informed of the missed doses of medication. Severity: 2 Scope: 1			
Y 885 SS=C	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be	Y 885		

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Y 885	Continued From page 4 deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Based on record review, observation and interview on 7/29/08, the facility did not ensure an expired medication for 1 of 1 residents had been destroyed. Findings include: Resident #1 was prescribed Alprazolam XR 2 mg tablet at bedtime as needed for sleep and the medication was filled on 6/14/07 with three refills. The medication was not listed on the medication administration records (MARs) from January through July of 2008 and the caregiver stated the resident was not been asking for the medication. The card of pills expired on 6/14/08 and had not been destroyed by the facility. Severity: 1 Scope: 3	Y 885		
Y 911 SS=C	449.2746(2)(d) PRN Medication Record NAC 449.2746 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (d) The results of the administration of the medication.	Y 911		

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Y 911	Continued From page 5 This Regulation is not met as evidenced by: Based on record review on 7/29/08, the facility did not ensure the results of "as needed" (PRN) medication administrations were documented for 4 of 4 residents. Findings include: Review of PRN medication logs revealed the results of the administration of PRNs to Residents #1, #2, #3 and #4 were not being documented by caregivers. Severity: 1 Scope: 3	Y 911		
Y 920 SS=C	449.2748(1) Medication Storage NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.	Y 920		

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Y 920	Continued From page 6 This Regulation is not met as evidenced by: Based on observation on 7/29/08, the facility did not ensure external medications for 2 of 2 residents were being stored separately from oral medications. Findings include: Residents #1 and #2 had external ointments and creams prescribed by their physicians. The tubes of medications were being stored in the same baskets as the resident's oral medications. Severity: 1 Scope: 3	Y 920		