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
	NVN285AGC		10/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAR-VON SENIOR CARE	300 LA RUE AVE RENO, NV 89509

(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 and Complaint Investigation conducted in your facility on 10/2/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 18 Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illnesses, Category I residents. The census at the time of the survey was 15. Ten resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. Complaint #NV00018791 was unsubstantiated. 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.	Y 000		
Y 070 SS=F	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review on 10/2/08, the facility failed to ensure 3 of 4 employees met the annual training requirements.	Y 070		

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 070	Continued From page 1 Findings include: Employees #1, #2 and #3 had all worked at the facility for more than 12 months. Employees #1 and #3 had no evidence of at least eight hours of annual training in their employee files. Employee #2 had evidence of only 3.5 hours of annual training in the last 12 months. Severity: 2 Scope: 3	Y 070		
Y 072 SS=F	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 10/2/08, the facility failed to ensure 2 of 2 employees who had previous medication training met the re-training	Y 072		

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Y 072	Continued From page 2 requirement. Findings include: Employees #1 and #2 completed initial medication training in 2005. Neither employee had evidence of at least three hours of medication re-training in the last three years. Severity: 2 Scope: 3	Y 072		
Y 175 SS=E	449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility. This Regulation is not met as evidenced by: Based on observation on 10/2/08, the administrator failed to ensure the facility was free of hazards. Findings include: 1. An upright vacuum cleaner and a folded wheelchair were stored in the exit corridor leading to the back door of the facility. 2. A basement access panel made of plywood was broken away from its frame. The panel was leaning against and into the ramp leading from the back door to the back yard. The upper rough edges and exposed screws on the panel were a hazard. 3. The facility dryer was located in the basement of the facility. The area behind and underneath the dryer had an accumulation of dryer lint.	Y 175		

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Y 175	Continued From page 3 Severity: 2 Scope: 2	Y 175		
Y 178 SS=C	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 on 10/2/08, the facility failed to ensure the wall tiles in 1 of 1 shower rooms were well maintained. Findings include: A main shower room was located in the hallway across from bedroom #6. Along the bottom edge of the shower, the grouting had eroded around four of the base tiles and they were leaning away from the wall. The four wall tiles above the base tiles had also detached from the wall and had slid down behind the base tiles. There were other areas of the tiled wall where there were gaps in the grouting around tiles. Severity: 1 Scope: 3	Y 178		
Y 876 SS=D	449.2742(4) NRS 449.037 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the	Y 876		

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Y 876	Continued From page 4 administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. This Regulation is not met as evidenced by: NRS 449.037 Adoption of standards, qualifications and other regulations. 6. The Board shall adopt separate regulations regarding the assistance which may be given pursuant to NRS 453.375 and 454.213 to an ultimate user of controlled substances or dangerous drugs by employees of residential facilities for groups. The regulations must require at least the following conditions before such assistance may be given: (d) The prescribed medication is not administered by injection or intravenously. NRS 453.375 Authority to possess and administer controlled substances. A controlled substance may be possessed and administered by the following persons: 6. An ultimate user or any person whom the ultimate user designates pursuant to a written agreement. Based on record review and interview on 10/2/08, the facility failed to ensure the files for 3 of 10 residents contained an ultimate user agreement and that 1 of 10 residents did not require caregiver assistance with an injectable medication. Findings include: 1. The files for Residents #1, #6 and #9 did not contain a signed medication assistance agreement with the facility.	Y 876		

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Y 876	Continued From page 5 2. Resident #9 was prescribed Fotteo 750 micrograms (mcg) per 3 milliliter (ml), 20 mcg daily. The medication was administered through an injection pen. Employee #2 reported she assisted the resident by turning the pen to the prescribed dose. Severity: 2 Scope: 1	Y 876		
Y 877 SS=D	449.2742(5) OTC medications & Dietary Supplements NAC 449.2742 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 medication and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. This Regulation is not met as evidenced by: Based on record review and interview on 10/2/08, the facility failed to ensure over-the-counter (OTC) medications given to 2 of 10 residents were approved by their physician. Findings include:	Y 877		

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Y 877	Continued From page 6 Resident #2: Physician's samples of I-Caps Multivitamins were in with the resident's other medications. Employee #2 reported the resident's physician provided the samples for the resident. She stated the resident started the pills on 8/12/08 and was taking them through the day of the survey. There was no physician's approval for the vitamins in the resident's file and the medication was not listed on the September or October 2008 medication administration records (MAR). Resident #10: Acidophillis chewable tablets, one every even day, was listed on the resident's MAR. Employee #2 reported the resident's daughter brought the medication to the facility and instructed the caregivers to give the medication to the resident. The facility did not obtain physician's approval for the medication. Severity: 2 Scope: 1	Y 877		
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 deemed to be an acceptable method of destruction of medication.	Y 885		

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Y 885	Continued From page 7 This Regulation is not met as evidenced by: Based on observation and interview on 10/2/08, the facility did not destroy 1 of 1 resident's medications after they were discontinued or had expired. Findings include: Resident #4 was prescribed Vesicare 10 milligrams (mg), one tablet daily, and it was listed on the September 2008 medication administration record (MAR) to be administered at 8:00 PM. It was noted on the multi-medication bubble packs that the Vesicare was discontinued on 9/29/08. Employee #2 reported the resident's physician instructed the facility to discontinue the administration of the medication but the facility did not receive a written order. The employee stated she was destroying the Vesicare tablets each night but had not documented the destruction. Resident #4 had two medication cards of Acetaminophen 500 mg tablets, prescribed as one tablet every eight hours as needed for pain. The medication was dispensed on 9/25/07 and expired on 9/24/08. The 64 tablets of expired medication had not been destroyed by the facility. Severity: 1 Scope: 3	Y 885		