

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS367AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2009
NAME OF PROVIDER OR SUPPLIER ST ANNES RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3158 KINGSPPOINT AVENUE LAS VEGAS, NV 89120		
(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 at your facility on 02/24/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received an annual survey grade of A. The facility was licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was 7. Seven resident files were reviewed and 7 employee files were reviewed. One discharged resident file was reviewed. 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. Complaint #NV00001950 was unsubstantiated. The following deficiencies were identified:	Y 000		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by:	Y 105		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS367AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2009
NAME OF PROVIDER OR SUPPLIER ST ANNES RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3158 KINGSPPOINT AVENUE LAS VEGAS, NV 89120		
(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 105	Continued From page 1 Based on record review on 02/24/09, the facility failed to ensure 2 of 7 employees met the FBI background check requirement (Employee #4 and #7). This was a repeat deficiency from the 03/07/08 State Licensure survey. Severity: 2 Scope: 3	Y 105		
Y 876 SS=A	449.2742(4) NRS 449.037 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the 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: Based on record review on 02/24/09, the facility failed to ensure that an ultimate user agreement was obtained for 1 of 7 residents (Resident #1). Severity: 1 Scope: 1	Y 876		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a	Y 878		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS367AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2009
NAME OF PROVIDER OR SUPPLIER ST ANNES RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3158 KINGSPPOINT AVENUE LAS VEGAS, NV 89120		
(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 878	Continued From page 2 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. This Regulation is not met as evidenced by: Based on observation, interview, and record review on 02/24/09, the facility failed to ensure that 1 of 7 residents received medications as prescribed (Resident #1). Findings include: Resident #1's medication bin contained half pills of 200 milligrams of Seroquel. Resident #1's medication administration record indicated 100 milligrams of Seroquel, half a tablet at bedtime for February 2009. On 02/16/09, a physician's order indicated 25 milligrams of Seroquel, 50 milligrams every morning. Employee #7 lacked an explanation reconciling the above discrepancies. Severity: 2 Scope: 1	Y 878		
Y 936 SS=F	449.2749(1)(e) Resident file	Y 936		

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

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS367AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2009
NAME OF PROVIDER OR SUPPLIER ST ANNES RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3158 KINGSPPOINT AVENUE LAS VEGAS, NV 89120		
(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 936	Continued From page 3 NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 02/24/09, the facility failed to ensure that 2 of 7 residents complied with NAC 441A.380 regarding tuberculosis (Resident #2 and #6) which affected all residents. Severity: 2 Scope: 3	Y 936		

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