STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295076		C 03/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENT-PARADISE VALLEY	2325 E. HARMON AVE. LAS VEGAS, NV 89119

(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	F 000		
	This Statement of Deficiencies was generated as the result of a Medicare complaint investigation which was conducted at your facility on March 10, 2009. The census at the beginning of the surevy was 102.			
	The following complaints were investigated:			
	Complaint #NV19740 - Substantiated (Tag F 309) Complaint #NV19392 - Unsubstantiated Complaint #NV19584 - Substantiated (Tags F 281, F 309, F 425)			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, 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 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		
	The services provided or arranged by the facility must meet professional standards of quality.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Controlled Drug Accountability Records were reconciled in accordance with the professional standards of quality set forth in the Nevada State Board of Nursing Nurse Practice Act (Nevada Administrative Code Chapter 632) and failed to			

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

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.

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F 281	Continued From page 1 ensure medications were appropriately administered via gastrostomy feeding tube. Findings include: 1. Document Review - Nevada State Board of Nursing Nurse Practice Act (Nevada Administrative Code Chapter 632) DISCIPLINARY ACTION AND PRACTICE BEFORE THE BOARD NAC 632.890 Unprofessional Conduct. 16. Failing to document properly the administration of a controlled substance, including, but not limited to: ... (c) Failing to document the wastage of a controlled substance that was not legally administered to a patient. - Facility's Pharmaceutical Services Manual- "CONTROLLED DRUGS-revised 8/03- pages 47-49 POLICY: Drugs listed in Schedules II through V of the Controlled Substances Act possess high abuse potential and are subject to special handling, storage, disposal and record keeping. PROCEDURES 1. Only authorized licensed nursing and pharmacy personnel may have access to Schedule II, III, IV, or V controlled drugs. ... 7. Each line on the Controlled Drug	F 281		

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F 281	Continued From page 2 Accountability Record represents one tablet or partial tablet (depending on dosage). If more than one sheet is needed for the number of doses dispensed a significant number of sheets should be provided. If the dispensing pharmacy fails to provide a Controlled Drug Accountability Record the nurse receiving the medication should request one immediately, and one should be provided within 24 hours. ... 9. If a dose is removed from the container but refused by the resident or not given for any reason, do not put it back in the container. It must be destroyed in the presence of two licensed nurses, and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of partial tablets and portions of single dose ampules or vials. 10. A physical inventory of all Schedule II, III, IV, and V drugs must be made at the change of each shift by two licensed nurses and is documented on an audit record. ... 12. Report any discrepancy in controlled drug counts to the director of nursing or designee immediately. The director or designee shall investigate and make every reasonable effort to reconcile all reported discrepancies. Document irreconcilable discrepancies in a report to the director of nursing and Executive Director. The director of nursing shall notify the Executive Director and consultant pharmacist immediately of any irreconcilable discrepancies or patterns of discrepancies, or if there is apparent criminal activity. The Executive Director will consult with the pharmacist concerning possible notification of police or other enforcement agencies."	F 281		

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F 281	Continued From page 3 Observation, Document Review, and Interview On 3/10/09 at 12:20PM, a medication pass was conducted. After the medication pass, the Controlled Accountability Record was reviewed for each resident with the staff nurse. Resident #3 The pre-numbered Controlled or Antibiotic Drug Record indicated 30 doses of Hydrocodone with APAP 5/500mg (milligrams) were delivered to the facility by the pharmacy on 2/13/09. Review of the pre-numbered Controlled or Antibiotic Drug Record indicated #23 was missing. There was no documented evidence to verify the reason for the missing tablet. On 3/10/09 in the afternoon, the licensed nurse had no explanation for the missing Hydrocodone. Resident #4 The pre-numbered Controlled or Antibiotic Drug Record indicated 30 doses of Temazepam 15 mg. capsule were delivered to the facility by the pharmacy on 1/20/09. The pre-numbered medication record #28- #16 indicated the resident received 13 doses signed by the licensed nurses. Review of the pre-numbered Controlled or Antibiotic Drug Record indicated #30, #29 and #8 tablets were missing. There was no documented evidence on the Drug Record to verify the reason for the missing tablets. On 3/10/09 in the afternoon, the licensed nurse had no explanation for the missing Temazepam capsules.	F 281		

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F 281	Continued From page 4 Resident #5 The pre-numbered Controlled or Antibiotic Drug Record indicated 30 doses of Alprazolam 0.5mg (Xanax) were delivered to the facility by the pharmacy on 12/1/08. The pre-numbered medication record #30- #27 indicated the resident received 3 doses signed off by the licensed nurses. Review of the pre-numbered Controlled or Antibiotic Drug Record indicated #8 tablet was missing. There was no documented evidence on the Drug Record to verify the reason for the missing tablet. On 3/10/09 in the afternoon, the licensed nurse had no explanation for the missing Alprazolam tablet. On 3/10/09 in the afternoon, the Director of Nursing stated the licensed nurse on 100/200 hallway found 2 pills on the bottom of the narcotic drawer and disregarded the pills before the pills were identified. 2. The Narcotic Signature Logs from the 100/200 hallway for the period 10/14/08 through 2/22/09 were reviewed. There was no documented evidence to verify during the following months narcotic counts were signed by two licensed nurses at the beginning and end of each shift: - October 2008 - 11 shifts - November 2008 - 11 shifts - December 2008 - 4 shifts - January 2009 - 11 shifts - February 2009 - 9 shifts The Narcotic Signature Logs from the 300	F 281		

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F 281	Continued From page 5 hallway for the period 12/24/08 through 3/10/09 were reviewed. There was no documented evidence to verify during the following months narcotic counts were signed by two licensed nurses at the beginning and end of each shift: - December 2008 - 2 shifts - January 2009 - 9 shifts - February 2009 - 12 shifts - March 2009 - 4 shifts The Narcotic Signature Log from the 400 hallway for the period 9/19/08 through 1/7/09 was reviewed. There was no documented evidence to verify the following months narcotic counts were signed by two licensed nurses at the beginning and end of each shift: - September 2008 - 3 shifts - October 2008 - 19 shifts - November 2008 - 18 shifts - December 2008 - 10 shifts - January 2009 - 2 shifts Interview On 3/13/09 in the afternoon, during a telephone interview, the Director of Nursing (DON) was not aware of the missing and empty narcotics documented on the Controlled Drug Accountability record by the licensed nurses. The DON was informed that the physical inventory sheets for the Scheduled narcotics were not consistently signed by two licensed nurses at the end of each shift. 2. Document Review Clinical Services Policy and Procedure, Nursing	F 281		

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F 281	Continued From page 6 Volume I Medication Administration, Chapter 13 Standard Medications are administered appropriately and safely when the resident has a feeding tube in place. Policy * Resident on continuous or intermittent tube feedings have tube clamped (one hour before and one hour after giving medication) if medication is incompatible with feedings. *Medication is administered, as ordered by a physician, by licensed nurse. Procedure 1. Identify resident ... 6. Attach syringe to end of the tube and insert 20cc (cubic centimeters) of air. a. Check placement and patency by auscultation. b. If tube is not adequately placed, do not give the medication and do not flush with water, but adjust placement of feeding tube or insert a new one. Observation and Interview On 3/10/09 during the noon medication pass, the licensed nurse administered Hydralazine 50mg. (milligrams) via gastrostomy tube. The licensed nurse did not check placement prior to administration of Hydralazine. After the administration of the Hydralazine, the licensed nurse assessed and observed the resident was in pain. The licensed nurse administered Ibuprofen 800mg. via gastrostomy tube. The licensed nurse did not check placement prior to administration of Ibuprofen. The medication pass was also	F 281		

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F 281	Continued From page 7 accompanied by the Director of Nursing who verified observing the licensed nurse failed to check tube placement prior to medication administration.	F 281		
	Complaint #NV19584			
F 309 SS=D	483.25 QUALITY OF CARE	F 309		
	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 interview and record review, the facility failed to ensure the resident received and was provided Foley catheter care, dental care, and administration of Oxygen in accordance with the plan of care for 1 resident (#1).			
	Findings include:			
	Resident #1			
	Resident #1 was re-admitted on 7/30/08 with the following diagnoses of Blood in Stool, Circulatory Disease, Debility, Morbid Obesity, Lumbago, Anemia and Atrial Fibrillation.			
	Record Review			
	1. On 10/18/08 at 12:30AM, the resident was transferred to a local emergency room for 2 units of packed red cells. On 10/19/08 at 2100			

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F 309	Continued From page 8 (8:00PM), the licensed nurse documented: "received resident in room, alert, responsive. Medicated for pain per request. Continues on Cipro for UTI (urinary tract infection)- incontinent of bowel, catheter patent, draining clear urine. Appears in no distress." On 10/20/08, 10/21/08, 10/22/08 , 10/27/08, 10/28/08, and 10/29/08 the licensed nurse documented: "catheter patent, draining clear urine." There was no documented evidence to verify a physician's order was obtained for the Foley catheter at the time the resident returned to the facility from the emergency room. There was no documentation the licensed nurse assessed the resident for the Foley catheter. 2. The October 2008 Daily Care Flow Report was completed by the certified nursing assistant (CNA). There was no documented evidence to verify the CNA provided the denture care to the resident on the following dates 10/10/08-10/11/08, 10/17/08, 10/25/08 and 10/31/08. The documentation provided by the facility and record review indicated the patient was sent to the emergency room on 9/12/08, 10/12/08 and 10/18/08. These dates did not correlate with the dates denture care was not provided. Interview On 3/10/09, the Director of Nursing and Executive Director indicated the resident was seen in the emergency room at a local hospital numerous times during her stay at the facility.	F 309		

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F 309	Continued From page 9 3. The licensed nurse documented the resident received Oxygen 2 liters on the following dates: 10/6/08, 10/12/08, 10/13/08, 10/21/08, 10/23/08, and 10/24/08. May 16, 2008 was the last documented physician's orders for Resident #1 which indicated Oxygen 2 liters per nasal cannula. The October 2008 physician's orders lacked any orders for Oxygen 2 liters per nasal cannula. Interview On 3/10/09, the Director of Nursing indicated the resident had been on continuous oxygen during her admission at the facility. Complaints #19740, #19584	F 309		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

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F 425	Continued From page 10	F 425		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure that the controlled substances ordered were accurately reconciled for 3 residents and the Controlled Drug Accountability record signed by the licensed nurses were not consistently signed at the end of the shifts by two licensed nurses.

Findings include:

Document Review

Facility's Pharmaceutical Services Manual-

"CONTROLLED DRUGS-revised 8/03- pages 47-49

POLICY: Drugs listed in Schedules II through V of the Controlled Substances Act possess high abuse potential and are subject to special handling, storage, disposal and record keeping.

PROCEDURES

1. Only authorized licensed nursing and pharmacy personnel may have access to Schedule II, III, IV, or V controlled drugs.

... 7. Each line on the Controlled Drug Accountability Record represents one tablet or partial tablet (depending on dosage). If more than one sheet is needed for the number of doses dispensed a significant number of sheets should

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F 425	Continued From page 11 be provided. If the dispensing pharmacy fails to provide a Controlled Drug Accountability Record the nurse receiving the medication should request one immediately, and one should be provided within 24 hours. ... 9. If a dose is removed from the container but refused by the resident or not given for any reason, do not put it back in the container. It must be destroyed in the presence of two licensed nurses, and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of partial tablets and portions of single dose ampules or vials. 10. A physical inventory of all Schedule II, III, IV, and V drugs must be made at the change of each shift by two licensed nurses and is documented on an audit record. ... 12. Report any discrepancy in controlled drug counts to the director of nursing or designee immediately. The director or designee shall investigate and make every reasonable effort to reconcile all reported discrepancies. Document irreconcilable discrepancies in a report to the director of nursing and Executive Director. The director of nursing shall notify the Executive Director and consultant pharmacist immediately of any irreconcilable discrepancies or patterns of discrepancies, or if there is apparent criminal activity. The Executive Director will consult with the pharmacist concerning possible notification of police or other enforcement agencies." Observation, Document Review, and Interview On 3/10/09 at 12:20PM, a medication pass was	F 425		

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F 425	Continued From page 12 conducted. After the medication pass, the Controlled Accountability Record was reviewed for each resident with the staff nurse. Resident #3 The pre-numbered Controlled or Antibiotic Drug Record indicated 30 doses of Hydrocodone with APAP 5/500mg (milligrams) were delivered to the facility by the pharmacy on 2/13/09. Review of the pre-numbered Controlled or Antibiotic Drug Record indicated #23 was missing. There was no documented evidence to verify the reason for the missing tablet. On 3/10/09 in the afternoon, the licensed nurse had no explanation for the missing Hydrocodone. Resident #4 The pre-numbered Controlled or Antibiotic Drug Record indicated 30 doses of Temazepam 15 mg. capsule were delivered to the facility by the pharmacy on 1/20/09. The pre-numbered medication record #28- #16 indicated the resident received 13 doses signed by the licensed nurses. Review of the pre-numbered Controlled or Antibiotic Drug Record indicated #30, #29 and #8 tablets were missing. There was no documented evidence on the Drug Record to verify the reason for the missing tablets. On 3/10/09 in the afternoon, the licensed nurse had no explanation for the missing Temazepam capsules. Resident #5 The pre-numbered Controlled or Antibiotic Drug	F 425		

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F 425	Continued From page 13 Record indicated 30 doses of Alprazolam 0.5mg (Xanax) were delivered to the facility by the pharmacy on 12/1/08. The pre-numbered medication record #30- #27 indicated the resident received 3 doses signed off by the licensed nurses. Review of the pre-numbered Controlled or Antibiotic Drug Record indicated #8 tablet was missing. There was no documented evidence on the Drug Record to verify the reason for the missing tablet. On 3/10/09 in the afternoon, the licensed nurse had no explanation for the missing Alprazolam tablet. On 3/10/09 in the afternoon, the Director of Nursing stated the licensed nurse on 100/200 hallway found 2 pills on the bottom of the narcotic drawer and disregarded the pills before the pills were identified. The Narcotic Signature Logs from the 100/200 hallway for the period 10/14/08 through 2/22/09 were reviewed. There was no documented evidence to verify during the following months narcotic counts were signed by two licensed nurses at the beginning and end of each shift: - October 2008 - 11 shifts - November 2008 - 11 shifts - December 2008 - 4 shifts - January 2009 - 11 shifts - February 2009 - 9 shifts The Narcotic Signature Logs from the 300 hallway for the period 12/24/08 through 3/10/09 were reviewed. There was no documented evidence to verify during the following months narcotic counts were signed by two licensed	F 425		

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LIFE CARE CENT-PARADISE VALLEY	2325 E. HARMON AVE. LAS VEGAS, NV 89119

(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 425	Continued From page 14 nurses at the beginning and end of each shift: - December 2008 - 2 shifts - January 2009 - 9 shifts - February 2009 - 12 shifts - March 2009 - 4 shifts The Narcotic Signature Log from the 400 hallway for the period 9/19/08 through 1/7/09 was reviewed. There was no documented evidence to verify the following months narcotic counts were signed by two licensed nurses at the beginning and end of each shift: - September 2008 - 3 shifts - October 2008 - 19 shifts - November 2008 - 18 shifts - December 2008 - 10 shifts - January 2009 - 2 shifts Interview On 3/13/09 in the afternoon, during a telephone interview, the Director of Nursing (DON) was not aware of the missing and empty narcotics documented on the Controlled Drug Accountability record by the licensed nurses. The DON was informed that the physical inventory sheets for the Scheduled narcotics were not consistently signed by two licensed nurses at the end of each shift. Complaint #19584	F 425		