

Bureau of Health Care Quality & Compliance

PRINTED: 11/29/2009
FORM APPROVED

*1-25-10
accepted
POC
C. Johnson*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5303AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2009
NAME OF PROVIDER OR SUPPLIER ADDIE'S HOME CARE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7955 TRAIL HEAD DR LAS VEGAS, NV 89113		
(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 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. This Statement of Deficiencies was generated as a result of an annual state licensure survey conducted in your facility on 11/2/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a survey grade of D. The following deficiencies were identified:	Y 000		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.	Y 103	<i>Y 103 a) EMPLOYEE # 1 HAD POSITIVE TB SKIN TEST SINCE 1993. SINCE THE SNHD CAN NOT PROVIDE THE RESULT THE EMPLOYEE # 1 TOOK ANOTHER TB SKIN TEST 12-28-09. POSITIVE RESULT OF TB SKIN TEST. EMPLOYEE # 1 HAVE DOCTOR'S APPOINTMENT FOR PHYSICAL CHECK-UP FEB. 8, 2010. EMPLOYEE # 1 HAD PHYSICAL CHECK-UP 4-18-09 WITH PHYSICIAN STATEMENT THAT NO SIGN OF TB. NEXT PAGE PLEASE</i>	<i>OK CJ</i>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Rebecca N. Wolfkill

TITLE *REBECCA WOLFKILL* ADMINISTRATOR (X6) DATE *1-7-10*

Bureau of Health Care Quality & Compliance

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Y 103	Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review on 11/2/09, the facility failed to ensure 2 of 3 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #1 and #3) Severity: 2 Scope: 3	Y 103	b) WHENEVER NEW EMPLOYEE COMING IN FOR EMPLOYMENT A PERSONEL FILE CHECKLIST WILL BE UTILIZED TO DETERMINE THAT ALL EMPLOYEE ARE CURRENT WITH ALL THE REQUIREMENTS. THE ADMINISTRATOR WILL MONITOR FOR COMPLIANCE. c) 12-30-09	<i>dk</i> <i>cf</i>
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: Based on record review on 11/2/09, the facility failed to ensure 2 of 2 caregivers met background check requirements (Employee #2, FBI report and #3 State report and Criminal History Statement). Severity: 2 Scope: 3	Y 105		
Y 274 SS=C	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a	Y 274		

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CARSON CITY, NEVADA

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Edith to ...

TITLE

Owner-administrator 12/28/09

(X8) DATE

Bureau of Health Care Quality & Compliance

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Y 103 SS=F	<p>449.200(1)(d) Personnel File - NAC 441A</p> <p>NAC 449.200</p> <p>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:</p> <p>(d) The health certificates required pursuant to chapter 441A of NAC for the employee.</p>	Y 103 TAG 11/6/09	<p>A-EMPLOYEE #1 TOOK A TUBERCULIN SKIN TEST IN 1993-(POSITIVE), OPENED A BUSINESS IN 1995-(POSITIVE AGAIN). HEALTH DEPT. SENT HER FOR AN X-RAY AND PHYSICAL, DOCTOR STATED SHE WAS IN GOOD HEALTH WITH NO SIGN OF T.B. AND SUBSEQUENT X-RAYS AND CHECK-UPS, ALSO NEGATIVE.</p> <p>EMPLOYEE #3 WAS ALSO POSITIVE ON STEP #1 OF A PPD AND WAS SENT FOR X-RAY AND CHECK-UP AND WAS FOUND TO BE NEGATIVE FOR T.B.</p>	OK cg

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Lydia to Linda Sykes

TITLE (X6) DATE
Owner-Administrator 12/28/09

Bureau of Health Care Quality & Compliance

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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: Based on record review on 11/2/09, the facility failed to ensure 2 of 2 caregivers met background check requirements (Employee #2, FBI report and #3 State report and Criminal History Statement). Severity: 2 Scope: 3	Y 105 TAG 12/17/08	A - EMPLOYEE #2 HAD AN FBI REPORT BACKGROUND CHECK DATED 12/17/08 IN HER FILE AT TIME OF SURVEY EMPLOYEE #3 HAD A STATE BACKGROUND REPORT AND A CRIMINAL HISTORY STATEMENT IN HIS FILE AT THE TIME OF THE SURVEY. (PROOF CANNOT BE SUBMITTED SINCE HE TOOK HIS FILE WITH HIM WHEN HE WAS TERMINATED. B - ALL EMPLOYEE FILES WILL BE REVIEWED EVERY SIX MONTHS FOR COMPLETION OF REQUIREMENTS BY THE ADMINISTRATOR. C - 11/19/09.	OK cg
Y 274 SS=C	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a	Y 274 TAG 11/03/09	A - SINCE MENU SUBSTITUTIONS WERE NOT PROPERLY POSTED A NEW MENU FORMAT ALLOWS FOR IMMEDIATE AND CLEARLY ADJACENT SUBSTITUTION POSTING. WEEKLY MENUS WILL BE POSTED AND FILED IN A CHRONOLOGICAL MANNER FOR EASY REVIEW	OK cg

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STATE FORM

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W6YR11

(Continuation sheet 2 of 8)

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Bureau of Health Care Quality & Compliance

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Y 274	Continued From page 2 conspicuous place during the service of the meal. This Regulation is not met as evidenced by: Based on observation and interview on 11/2/09, the facility failed to ensure menu substitutions were documented and retained for at least 90 days. The facility failed to follow the posted menu for 2 of 2 meals observed in the facility. The facility failed to document the substitutions. Severity: 1 Scope: 3	Y 274	B - ADMINISTRATOR WILL REVIEW MENUS AND ALL SUBSTITUTIONS AT LEAST EVERY SIX MONTHS. D - 11/3/09.	
Y 444 SS=F	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by: Based on record review on 11/2/09, the facility failed to ensure all smoke detectors were tested 12 out of the past 12 months. The facility failed to provide evidence that each smoke detectors had been checked every month. Severity: 2 Scope: 3	Y 444 TAG 12/12/09	A - SMOKE DETECTOR RULES HAVE BEEN FOLLOWED SINCE THIS FACILITY OPENED BUT EACH DETECTOR WAS NOT TESTED INDIVIDUALLY EACH MONTH. NOW WE TESTED INDIVIDUALLY. WE NOW ARE USING A NEW SMOKE DETECTOR TESTING LOG ON WHICH EACH DETECTOR'S TEST RESULTS ARE KEPT FOR EACH MONTH AND FILED FOR REVIEW. DETECTOR FILE B - THE SMOKE DETECTOR FILE WILL BE REVIEW QUARTERLY FOR COMPLIANCE C - 11/10/09.	copy of log
Y 451 SS=F	449.231(2)(a)-(f) First Aid Kit	Y 451	A - A FIRST AID KIT WAS AVAILABLE AT THE TIME OF THE SURVEY WHICH WAS LACKING ONLY A G.P. SHIELD	no receipt is file mask

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Y 451	Continued From page 3 NAC 449.231 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans. (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or device that may be used to determine the bodily temperature of a person. This Regulation is not met as evidenced by: Based on interview and observation on 11/2/09, the facility failed to have a first aid kit available with all the required components (A shield or mask for cardiopulmonary resuscitation). Severity: 2 Scope: 3	Y 451 TAG 12/26/09	B - A C.P.R. SHIELD WAS PURCHASED AND ADDED TO THE FIRST AID KIT AND THE KIT WILL BE EXAMINED EVERY 34 MONTHS TO INSURE ITS COMPLETENESS. C - 12/26/09.	photo or receipt
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Y 877 SS=E	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	Y 877 TAG 12/17/09	A - RESIDENT #4 - WE TRIED TO CONTACT THE DOCTOR BUT HE WAS ON EXTENDED VACATION THE NEXT DAY 11/3/09 HER DAUGHTER TOOK HER TO ANOTHER DOCTOR WHO PRESCRIBED OTHER MEDICATION BUT DID NOT O.K ADMINISTRATION OF THE PRECIBEC. IT WAS DISCONTINUED. RESIDENT #5 WAS UNABLE TO OBTAIN DOCTORS ORDERS FOR THE SUPPLEMENTS AND THEY WERE REMOVED FROM	OK CG
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Y 877 Continued From page 4
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 11/2/09, the facility did not obtain physician orders to administer dietary supplements to 2 of 5 residents (Resident #4 - Prilosec and Resident #5 - Blue Green Algae, Organic Spirulina, Milk Thistle, Ribonucleic Acid, Melatonin and Vitamin B Complex).

Severity: 2 Scope: 2

Y 883 SS=E 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.

This Regulation is not met as evidenced by: Based on record review and interviews on 11/2/09, the facility had no evidence physicians

Y 877

THE FACILITY ON 12/17/09 WITHOUT BEING ADMINISTERED
B - ALL MEDICATIONS COMING INTO THE FACILITY ARE NOW BEING CROSS-CHECKED TO INSURE THAT THE RESIDENTS DOCTOR PRESCRIBED OR APPROVED ITS INCLUSION FOR THAT RESIDENT AND THE MAR AND DOCTORS ORDERS ARE REVIEWED AT LEAST ONCE A MONTH BY THE ADMINISTRATOR.
C - 12/17/09

OK CG

Y 883

tag 12/2/09

A - RESIDENT #4 IS A MENTAL PATIENT WHO REFUSED MEDICATION WHICH HER SPOUSE ALSO TAKES FOR ALZHEIMERS AN ATTEMPT TO CONTACT HER DOCTOR FAILED DUE TO HIS EXTENDED VACATION. THE NEXT DAY SHE WAS TAKEN TO AN ALTERNATE DOCTOR WHO WROTE NEW PRESCRIPTIONS FOR PROZAC AND ARICEPT. SHE TOOK THEM FOR SIX DAYS THEN AGAIN REFUSED TO TAKE MEDICATION, BECAME VIOLENT AND ABUSIVE AND INSISTED ON GOING TO A HOSPITAL. THE EMT'S CAME TOOK HER AWAY AND SHE DID NOT RETURN TO THIS HOME.

OK CG

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Y 895	Continued From page 6 Findings Include: On 11/02/09, at 9:45 AM, the MAR for 5 of 5 residents was not signed for the morning or evening medications on 11/01/09 or morning medications on 11/02/09. Severity: 1 Scope: 3	Y 895	ON 11/2/09 ALL RESIDENTS #1 THRU #5 WERE INTERVIEWED AND HAD TAKEN THEIR EVENING DOSAGES ON 11/1/09 AND THEIR MORNING DOSAGES ON 11/2/09.	ok
Y 908 SS=B	449.2746(2)(a)-(f) 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: (a) The reason for the administration. (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Based on record review on 11/02/09, the facility failed to ensure the medication record was complete for 2 of 5 residents receiving as needed (PRN) medications (Resident #1 and #3).	Y 908	A - EMPLOYEE #3 WAS SEVERELY NEGLIGENT ON SEVERAL SCORES, ONE OF WHICH WAS HIS COMPLETE FAILURE TO PROPERLY RECORD THE PRN ADMINISTRATION. HE WAS TERMINATED. TAG - RESIDENT #1'S PRN WAS CHANGED TO REGULAR PRESCRIPTION FOR HYDROXIZINE PAM 50MG TAKING 1 CAP 3X DAILY 11/16/09 RESIDENT #3 HAS BEEN CHANGED TO HYDROXIZINE 100MG - 1 CAP AT BED TIME AND TAMAZEPAM 1 CAP @ 3ET ME B - FUTURE PRN RECORDS WILL BE KEPT ACCORDING TO REGULATION AND WILL BE MONITORED FOR COMPLIANCE BY THE ADMINISTRATOR AND REVIEWED MONTHLY. C - 11/19/09.	ok c.g.

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continuation sheet 7 of 8

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Y 908	Continued From page 7 Severity: 1 Scope: 2	Y 908		
Y 936 SS=F	449.2749(1)(e) Resident file-NRS 441A Tuberculosis 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 11/02/09, the facility failed to ensure 1 of 5 residents complied with NAC 441A.380 regarding tuberculosis (Resident #1 - no evidence that 2nd step was read) which affected all residents. Severity: 2 Scope: 3	Y 936 TAG 10/08/09	A - RESIDENT # 1 WAS GIVEN A SECOND STEP PPD ON 10/5/09 WHICH WAS READ ON 10/8/09. B - RESIDENT FILES ARE KEPT IN A LOCKED AND FIRE RESISTENT LOCATION AND ARE AS COMPLETE AS POSSIBLE AND ARE AVAILABLE FOR REVIEW BY ADMINISTRATOR OR SURVEYOR. C. 11/3/09.	-ok copy

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LAS VEGAS, NEVADA

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If continuation sheet 8 of 8

EDILBERTA M. De GUZMAN. ASSIST ADMINISTRATOR - OWNER

Addie's Home Care, Inc.

State Licensure Survey

11/02/09

Confidential Resident/Employee Identifier List

The following numerical identifiers have been assigned to the residents for purposes of confidentiality.

1. Rioh Pheigh
2. Keith Greb
3. Belinda Watson
4. Catherine Matteo
5. Charles Chiakulas
6. Cheryl Bigby, Discharged Resident

The following numerical identifiers have been assigned to the employees for purposes of confidentiality.

1. Rebecca Wolfkill, Administrator
2. Ediberta DeGuzman, Caregiver
3. Cesar DeGuzman, Caregiver

TAG Y103

SOUTHERN NEVADA HEALTH DISTRICT
P.O. Box 3902 • 625 Shadow Lane
Las Vegas, NV 89127

SKIN TEST REPORT

S.S. or H.C. # 1546402

Name: Wolfkill, Rebecca N.

The above patient had a skin test for Tuberculosis on

12-28-09 and was read as 21 mm on
positive reaction

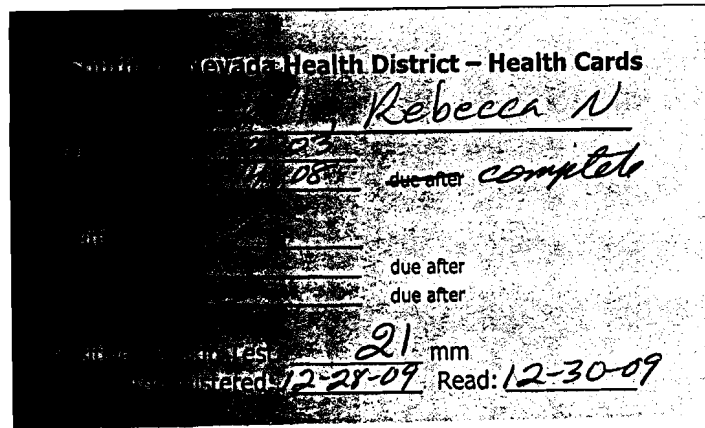
12-30-09. A second test was given on _____

and was read as _____ mm on _____

This is a positive TB Test. Xray only in future.

Chaegey LP

For Lawrence Sands, DO, MPH, Chief Health Officer



TAG Y 103



Print

Continue

P.O. Box 3902, Las Vegas, NV 89127
702.759.1099

Health Cards

12/28/2009

CUSTOMER RECEIPT

Name: WOLFKILL, REBECCA N**SEE NOTES**
Birth Date: 02/17/1951
Address: 6344 VILLA EMO STREET
NORTH LAS VEGAS, NV 89031-
Amount Paid: \$30.00 Charge To:
Admin Fee: \$20.00
Phone #: (702) 644-8270 Ext.



Health Card #: 1546402
Health Card Classification: SKIN TEST ONLY 2 STEP
Expiration Date: 12/28/2011

Your temporary Health Card is valid for 30 days. In order to receive your permanent Health Card, the following requirement(s) still need to be completed.

2ND SKIN TEST *waived*

PLEASE REPORT TO THE NURSE'S STATION MUST RETURN FOR READING AS DIRECTED BY THE NURSE.
EXAMEN DE LA TUBERCULOSIS POR FAVOR DIRIGIRSE AL PUESTO DE LA ENFERMERA DEBE REGRESAR PARA INTERPRETER LOS RESULTADOS CUANDO LO INDIQUE LA ENFERMERA.

*2/28/09
LFA
@ 2:00*

SKIN TEST (2 YR) *Return 12/30/09 From 2:00-3:30 or 12/31/09 From 8:00-3:30*
PLEASE REPORT TO THE NURSE'S STATION MUST RETURN FOR READING AS DIRECTED BY THE NURSE.
EXAMEN DE LA TUBERCULOSIS POR FAVOR DIRIGIRSE AL PUESTO DE LA ENFERMERA DEBE REGRESAR PARA INTERPRETER LOS RESULTADOS CUANDO LO INDIQUE LA ENFERMERA.

*Step 1 PPD 21mm
12/30/09
2PM [Signature]*

*12/30/09
Xray not indicated.
Normal CXR 627-08
Symptom review negative.
@Rebecca
12/30/09*

HEALTH CARDS INTERVIEW FORM

TAG Y 103

DATE: 12/30/09
NAME: Wolfkill, Rebecca N
DOB: 2-17-1951
GENDER: Female
H/C # 1546402 - STD -
COUNTRY OF BIRTH: P.F.

PPD RESULT: 21 mm (Reactor), (Converter)
X-RAY: SNHD / PRIVATE
COMMENTS: Needed PPD for documentation for state. Has had history of PST 1993 or 1994. Last CXR 6/27/08 (NC)
NURSE'S SIGNATURE: Creeger RN

Have you been in contact with a person with active TB? NO

When was you last chest x-ray 6/27/08

Have you ever had a TB skin test: Quantiferon blood test

Where was it taken SNHD
Xray not indicated

If yes, was it Negative or Positive (Circle one)

When was your last TB skin test and/or Quantiferon blood test 12/28/09

Comments/

Do you have:	YES	NO	Date of Onset
1. Cough lasting three or more weeks		NO	
2. Coughing up blood		NO	
3. Unexplained weight loss		NO	
4. Loss of appetite		NO	
5. Fever		NO	
6. Night sweats		NO	
7. Extreme tiredness/fatigue		NO	
8. A smoking habit		NO	

Have you been diagnosed with any of the following medical conditions?

1. Diabetes		NO	
2. Lupus Erythematosus		NO	
3. Rheumatoid Arthritis		NO	
4. Sarcoidosis		NO	
5. Kidney failure / Dialysis		NO	
6. Cancer, Lymphoma or Leukemia		NO	
7. Chemotherapy		NO	
8. Organ transplant		NO	
9. HIV or AIDS		NO	
10. Blood clotting disorder		NO	
11. Epilepsy or Seizure disorder		NO	
12. Liver Disease or Hepatitis		NO	
13. History of Gastrectomy		NO	
14. History of any lung disease		NO	

Have you ever been treated for active TB or TB Infection?

Are you on any medication?

NO
Lipitor, Benicar, Omeprazole, Thyroid

Have you had any recent surgeries:

NO

If female:

1. Are you pregnant

2. Are you currently breast feeding

NO
NO

CLIENT'S SIGNATURE

Rebecca N. Wolfkill

GENERAL PHYSICAL EXAM/SYSTEMS REVIEW

DATE OF SERVICE: 4/13/09

PATIENT NAME: Wolfehill, Rebecca

DOB: 2/17/51

SUBJECTIVE FINDINGS: _____

none

OBJECTIVE FINDINGS: V/S: B/P 124/80 P 68 R 16 TEMP. 98.6

HEIGHT: 5' WEIGHT: 130

a, 0 x 3

CLINICAL FINDINGS:

EENT: _____

LUNGS: _____

HEART: _____

ABDOMEN: _____ ai

EXTREMITIES: _____

SKIN: _____

MENTAL/NEURO: _____

ASSESSMENT/DIAGNOSES: physically fit

PLAN: cont med for hypertension as hypertensive hyp

no need for TB skin test as per 3/5/09

no sign of PTD

PHYSICIAN PRINTED NAME: Francis Jones

DATE: 4/13/09

PHYSICIAN SIGNATURE: [Signature]

4-431
TAG 11/10/09

Addies Home Care

RECEIVED
JAN 11 2010
BUREAU OF LICENSURE
AND CERTIFICATION
CARSON CITY, NEVADA

CVS/pharmacy
for all the ways you care

4014 S. RAINBOW, LAS VEGAS, NV
(702) 873-5917

REG#01 TRAN#8019 CSHR#803119 STR#8809

ExtraCare Card #: *****2121

1 GP... 6.70T	
1 N95 FLU MASK 1CT	2.99T
1 N95 FLU MASK 1CT	2.99T
1 N95 FLU MASK 1CT	2.99T

4 ITEMS

SUBTOTAL	15.76
NV 8.1% TAX	1.28
TOTAL	17.04
DEBIT	17.04
*****9546	MS
CHANGE	.00



2508 8099 3148 0190 10
RETURNS WITH RECEIPT THRU 01/09/2010

NOVEMBER 10, 2009 11:19 AM

EARN 2% BACK ON ALMOST EVERYTHING
IN THE STORE AND ON CVS.COM WHEN YOU
USE YOUR EXTRACARE CARD.

THANK YOU. SHOP 24 HOURS AT CVS.COM

ExtraCare Card balances as of 10/11

FALL 2009 SPENDING: 8.47

2009 CVS BRAND SAVINGS: 5.89

RECEIPT FOR FLU MASK

save money, earn rewards. see back for details. save money, earn rewards. see back for details. save money, earn rewards. see back for details.

Tag - 4 451

12/26/09

RECEIPT OF
SHIELD MASK

YOUR RECEIPT
THANK YOU

12/26/2009 11:33AM 01
000000#3474 CLERK01

DEPT. 01	T	\$3.95
MDSE ST		\$3.95
TAX1		\$0.32

ITEMS	1Q	
***TOTAL		\$4.27
CASH		\$5.00
CHANGE		\$0.73

*Shield or mask to be used
by a person who is administering
cardio pulmonary resuscitation.*

SMOKE DETECTOR TEST

NAC 449.229 (8)

REGULAR COPY of LOG
SMOKE DETECTORDate of Test: 10/10/09**Results:**

Location	Works	Needs Repair	Location	Works	Needs Repair
Kitchen	yes	no			

Signature of Staff Conducting Test: Cesar RodriguezDate Repairs Completed: 10/10**SMOKE DETECTOR TEST**Date of Test: 11/02/09**Results:**

Location	Works	Needs Repair	Location	Works	Needs Repair
Kitchen	yes	no	Dining room	yes	no
Bedroom 1	yes	no			
Bedroom 2	yes	no			
Bedroom 3	yes	no			
Bedroom 4	yes	no			

Signature of Staff Conducting Test: Albi M. de SigaonDate Repairs Completed: 11/02/09**SMOKE DETECTOR TEST**Date of Test: December 12/09**Results:**

Location	Works	Needs Repair	Location	Works	Needs Repair
Bedroom 1	yes	no	Dining room	yes	no
Bedroom 2	yes	no			
Bedroom 3	yes	no			
Bedroom 4	yes	no			
Kitchen	yes	no			

Signature of Staff Conducting Test: Albi M. de SigaonDate Repairs Completed: 12/05/09

ADDIES HOME CARE
EMPLOYEE # 3

TAG Y103
11/6/09



Eight Tower Bridge
161 Washington Street - Suite 1400
Conshohocken, PA 19428
TakeCareHealth.com • 1-866-Take-Care (1-866-825-3227)

Tuberculosis Skin Test Results

Patient Name: Cesar Deguzman

Patient DOB: 05-18-1974

Date TB test administered: 11.03.09

Date TB test read: 11.06.09

Take Care Provider Reading Test: M. LaPrest PA-C

Result of TB test: ~ 25 mm (Positive/Negative)

Additional Comments: CXR needed. Patient referred to Clark County Health District - TB Clinic. Can also see PCP.

I understand that the results of the Tuberculosis Test. The Take Care Provider has provided me with clear discharge instructions and I acknowledge that I am responsible for adhering to these discharge instructions.

[Signature]
Signature of Patient Receiving TB Test (or parent/guardian)

11/6/09
Date

[Signature] PA-C
Signature of Take Care Provider reading TB Test

11/6/09
Date

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Hobbies Home Care

TAG Y 103
12/16/09

EMPLOYEE # 3

RED ROCK MEDICAL CENTER

5701 W Charleston Blvd # 100, Las Vegas, NV 89146.

Phone: (702) 877-9514

211250 DEGUZMAN CESAR M 05/18/1974 11/09/2009 CXR

X-Ray Chest PA & Lateral view.

Both lung fields are clear.

Both apices and CP angles are clear.

Both diaphragmatic contours are normal.

Cardiac shadow within normal limits.

Soft tissues and rib cage do not reveal any abnormality.

The pre & retro-cardiac spaces are clear on Lateral view.

No e/o mediastinal mass.

OPINION:- NORMAL FINDINGS.

RD PRABHU
s/d R.D.Prabhu M.D.

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DEC 20 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Addies Home Care

TAG 4105
12/17/08

NEVADA DEPARTMENT OF PUBLIC SAFETY
CRIMINAL HISTORY RECORDS REPOSITORY
APPLICANT FINGERPRINT RESPONSE

ADDIES HOME CAR INC
EDILBERTA M DEGUZMAN OR JOSEPH FLINT
7955 TRAIL HEAD DR
LAS VEGAS, NV 89113

REFERENCE

ACCOUNT NUMBER: 881486

DATE FINGERPRINTED: 2008/08/25

APCN:
PS0223370A

NAME:
DEGUZMAN, EDILBERTA M

DOB:
1938/02/04

OCA:
881486

FBI NEGATIVE

A TECHNICAL FINGERPRINT SEARCH OF THE ABOVE INDIVIDUALS FINGERPRINTS WAS PERFORMED THROUGH THE FBI INTEGRATED AUTOMATED FINGERPRINT IDENTIFICATIONS SYSTEM (IAFIS)

PURSUANT TO NRS 179A.210, BASED ON THE INFORMATION RECEIVED FROM THE BACKGROUND CHECK, IT HAS BEEN DETERMINED THAT NO PRIOR CRIMINAL HISTORY INFORMATION EXISTS FOR WHICH NOTICE IS SUBJECT TO RELEASE.

OR

PURSUANT TO NRS 449.188, BASED ON INFORMATION RECEIVED FROM THE BACKGROUND CHECK, IT HAS BEEN DETERMINED THAT, THIS SUBJECT HAS NOT BEEN CONVICTED OF A CRIME LISTED IN NRS 449.188.

THE INFORMATION CONTAINED IN THIS DOCUMENT IS PROVIDED IN ACCORDANCE WITH THE PROVISIONS OF NEVADA REVISED STATUTE (NRS) 179A.180 - 179A.210. THIS RESPONSE IS BASED ON THOSE RECORDS, DATABASES, AND DOCUMENTS AVAILABLE TO THE CENTRAL REPOSITORY OF NEVADA RECORDS CRIMINAL HISTORY AT THE TIME THE BACKGROUND CHECK WAS PERFORMED. THE INFORMATION IN THIS DOCUMENT SHOULD NOT BE CONSTRUED TO PRECLUDE THE EXISTENCE OF A CONVICTION RECORD OR ADDITIONAL RECORDS OF THE TYPES LISTED IN NRS 179A.190 WHICH MAY BE IN A RECORD, DATABASE OR DOCUMENT NOT AVAILABLE OR ACCESSIBLE BY THE CENTRAL REPOSITORY. USE OF THIS INFORMATION IS REGULATED BY LAW. IT IS PROVIDED FOR OFFICIAL USE ONLY AND MAY BE USED ONLY FOR THE PURPOSE REQUESTED. DISSEMINATION TO A SECOND PARTY OR ENTITY IS PROHIBITED.
REVISED 062608

DATE REPORT GENERATED: 2008/12/17

NEVADA DEPARTMENT OF PUBLIC SAFETY
RECORDS AND IDENTIFICATION BUREAU

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DEC 28 2008

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

WEEKLY MENU

11/1/09 TUESDAY
 11/7/09 THURSDAY

4-277
 766.11/03/09

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
BREAKFAST 7:30 AM	OATMEAL MUFFIN	FRENCH TOAST BACON	FRUIT TOAST MILK COFFEE	HOT CREAM TOAST MILK COFFEE	CHEESE OMLET MUFFIN	PANCAKES SAUSAGE MILK COFFEE	SCRAMBLED EGGS HASH BROWNS MILK COFFEE
LUNCH 12:00 Noon	HAM & CHEESE SANDWICH RAVEN'S SOUP LETTUCE & TOMATO MILK JUICE MELON	TURK MEAT CORN OF CHICKEN SOUP SALAD MILK JUICE FRUIT	CHICKEN SANDWICH TOSSED GREEN SALAD MILK JUICE CANNED PEACH	HAMBURGER FRESH FRUIT CUTE SALAD MILK JUICE GRAPES	PIZZA PARROT CELERY MILK SODA FRUIT	HOT DOG BEANS CHIPS MILK SODA APPLE	TURKEY SANDWICH TOMATO SOUP CUCUMBER SLICES MILK SODA PINEAPPLE
DINNER 5:00 PM	MEAT LOAF MASH POTATOES PEAS MILK SODA CAKE	BAKED CHICKEN PARROT CORN MILK SODA BROCOLI	RAVIOLE GARLIC BEANS TOSSED SALAD MILK SODA PODDING	STILE FRY STEAK & VEG STEAMED RICE MILK SODA ICE CREAM	BAKED PIZZA PARROT BROCOLI MILK SODA PIE	FISH STEAKS FRESH FRUIT GREEN BEANS MILK SODA ICE CREAM	ROASTED CHICKEN MASHED POTATO SPINACH MILK SODA SHERBERT

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 DEC 28 2009

Tag - 4 451
12/26/09

YOUR RECEIPT
THANK YOU

12/26/2009 11:33AM 01
000000#3474 CLERK01

DEPT. 01	T1	\$3.95
MDSE ST		\$3.95
TAX1		\$0.32

ITEMS	10	
***TOTAL		\$4.27
CASH		\$5.00
CHANGE		\$0.73

Shield or mask to be used by a persons who is administering cardio pulmonary resuscitation.

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

4-877
12/17/09
LAS VEGAS NV
JAG
12/17/09

SINCE I WAS NOT ABLE TO OBTAIN
THE DOCTORS AUTHORIZATION TO USE
THEM, THE FOLLOWING DIETARY
SUPPLEMENTS WERE REMOVED FROM
MY GROUP HOME BY MY MOTHER (GUARDIAN);

BLUE GREEN ALGAE
ORGANIC SPIRULINA
MILK THISTLE
RIBONUCLEIC ACID
MELATONIN
VITAMIN B COMPLEX

ALL DOSES OF EACH OF THE ABOVE
SUPPLEMENTS WERE REMOVED.

Charles Crivello
RESIDENT # 5

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DEC 23 2009

BUREAU OF LICENSURE AND REGULATION
LAS VEGAS, NEVADA

Taq - 4908
11/16/09

11/16/09

To. Mr. Montecarlo as nurse.

Since Belinda Watson is taking Hydroxyzine
regularly instead PRN the Bureau of
Licensure suggest to write the prescription
regularly instead PRN.

Thanks,
Addie's Home Care

Hydroxyzine $\frac{1}{2}$ Temorepm

are given at bedtime

regularly, ~~not~~ prn

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DEC 2 8 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

AGNES P. MORTEL, MD
5025 Alta Drive Las Vegas, Nevada 89107

Tag #938
tag 9-938
10/08/09

Tuberculin Skin test (Mantoux)

Patient name: Rioh Pheigh SSN: _____

First step

Date given: 9/25/09 Site: ① FA Size: _____

Induration: 0 mm Date read: 10/2/09

Manufacturer: JHP Lot: 111057

Expiration: 11/10 Administered by: Afferson / Emma

Second step

Date given: 10/5/09 Site: ② FA Size: _____

Induration: 0 mm Date read: 10/8/09

Manufacturer: JHP Lot: 111057

Expiration: 11/10 Administered by: Afferson / Emma

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Southern Nevada Adult Mental Health Services
Residential Programs

Incident/Accident Report

Directions: Fill out report completely within 24 hours of incident. Make sure that Residential Programs and the Service Coordinator has a copy of the incident report within 48 hours of incident. If more than one client from the facility was involved in the incident, fill out a separate report for each individual.

Report prepared by ELMEN DOBIC Date of Report 12-2-09

Name of group home facility/Provider RODIE'S HOME CARE

Incident Date and Time 12/2/09 Location of Incident 7955 TRON HORN DR. NV

Client Name CATHY MATH

Date of Birth 11/9/42 Gender FEMALE Ethnicity CAUCASIAN

Caseworker PRIVATE CLIENT

Type of Incident (please check all that apply)

- AWOL / Eloped / Missing
- Physical Aggression
- Threat of Violence
- Verbal Aggression
- Abuse / Neglect
- Destruction of Property
- Death
- Injury / Illness
- Legal / Criminal
- Suicide
- Sexual incident
- Weapon possession
- Suicide Attempt
- Suicide Threat
- Contraband (drugs or alcohol)
- Medication (dosage or omission)
- Medication other (please specify)
- Other (please specify)

Description of Incident/Accident: ON ABOVE TIME AND DATE CATHY MATH BECAME VERY ABUSIVE AND MAKING THREATS. VERBALLY ABUSIVE MAKING THREATS TO ME AND SOME PWT. CATHY THROW 2 PLASTIC GLASSES WITH WATER ON ME ON THE KITCHEN. THROWING ALL HER STUFF ON THE HALLWAY. CATHY REFUSED TO TAKE HER PRESCRIBED MEDICATION SINCE NOV. 28. HER NAVIGATOR KIM WAS NOTIFIED AND HER MOTHER. WITH THE THREAT CATHY WAS DOING I CALLED 911 AND SHE WAS TAKEN TO THE HOSPITAL BY

(please complete reverse side)

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DEC 2 2 2009

Known Witnesses to the event:

Name _____ Position _____
 Name _____ Position _____

Actions taken by provider (please check all that apply)

- Notified 911
- Notified legal guardian
- Notified CPS/APS
- Notified police
- Notified Residential Programs
- Notified Crisis Phone (486-8020)
- Notified BLC
- Notified Service Coordinator
- Other (please explain below)

Describe actions taken by provider: Called 911

CATHY MATEO WAS TAKEN TO THE HOSPITAL FOR EVALUATION
DAUGHTER KIM ^{WIPER} WAS NOTIFIED BEFORE I CALLED 911 AND AFTER CATHY WAS TAKEN TO THE PSYCHIATRY

List current medications and dosages:

prilosec 20.6 mg
Floaxetine HCl 20 mg
aspirin 81 mg
perphenone 0.05 mg
aspirin 10 mg

Blumen Hobbs 12-2-09
 Provider Signature Date

Crisis/Serious Incident Reporting Procedures

For SNAMHS Clients

1. Call Case Manager (Service Coordinator-SC)
2. If unavailable, ask for a supervisor
3. If after hours, call the designated on-call SC
4. If unavailable, call Crisis (486-8020)
5. If a PACT client, call PACT on-call (389-7938)

For Mojave Clients

1. Call Case Manager (Service Coordinator-SC)
2. If unavailable, call Mojave front desk (968-5000), ask for Jason Schwartz or any supervisor
3. If after hours, call Crisis (486-8020), identify client as Mojave client, Crisis will contact Mojave on-call SC

RECEIVED

For office use only				Received:	
Class:	Serious	Severity:	Critical (1)	Div. Report and follow-up required	
	Complaint		Serious (2)	Div. Report and follow-up required	
	Other		Moderate (3)	RP report/follow up: in home	
			Low (4)	RP report/follow up: letter/call	
Category:			Information Only (5)	No action needed	
follow-up:			routed:		

BUREAU OF LICENSURE AND CERTIFICATION
 LAS VEGAS, NEVADA

TAG Y103



Print | Continue

P.O. Box 3902, Las Vegas, NV 89127
702.759.1099

Health Cards

08/14/2008

CUSTOMER RECEIPT

Name: WOLFKill, REBECCA N
Birth Date: 02/17/1951
Address: 6344 VILLA EMO STREET
North Las Vegas
NORTH FORK, NV 89031-
Amount Paid: \$65.00 Charge To:
Admin Fee:
Phone #: (702) 644-8270 Ext.

FOODSERVICE TRAINING
AUG 18 2008



Health Card #: 1378949
Health Card Classification: FOOD HANDLER/AGC/CC-R
Expiration Date: 08/14/2010

*History Pas PPD
no RECORDS
NO XR 1993 - 2003*

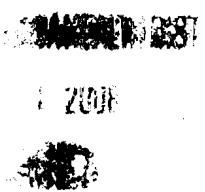
Your temporary Health Card is valid for 30 days. In order to receive your permanent Health Card, the following requirement(s) still need to be completed.

MOVIE (2 YR)

PLEASE REPORT TO THE AUDITORIUM AT LEAST 30 MINUTES PRIOR TO MOVIE TIME, SEATING IS LIMITED. FOOD HANDLERS CLASS MUST BE ATTENDED WITHIN 30 DAYS. FAILURE TO COMPLY WILL REQUIRE CLASS ATTENDANCE PRIOR TO REAPPLICATION AND ADDITIONAL HEALTH CARD FEE.
PELICULA DE ENTRENAMIENTO DE PREPARACIÓN DE ALIMENTOS POR FAVOR DIRIGIRSE AL AUDITORIO POR LO MENOS 30 MINUTOS ANTES DE QUE COMIENZE LA PELICULA YAQUE LOS ASIENTOS SON LIMITADOS. CARGOS DE TARDANZA SI NO SE COMPLETA ANTES DE LOS 30 DIAS.

XRAY TEST (2 YR) APPROVED BY: *[Signature]* 8/14/08 SNHD - HC. NV

[] IF SPECIFIED AND APPROVED BY SNHD STAFF - PLEASE REPORT TO DIAGNOSTIC IMAGING, 3560 E. FLAMINGO. CLEARANCE TAKES 7-10 DAYS. (NOTE: XRAY FEE NOT COVERED IF NOT SIGNED BY AUTHORIZED REPRESENTATIVE)
[] RAYOS X POR FAVOR DIRIGIRSE AL DIAGNOSTIC IMAGING, 3560 E. FLAMINGO RESULTADOS TARDAN ENTRE 7 Y 10 DIAS. . . .
DIAGNOSTIC IMAGING: PLEASE COMPARE TO OLD FILMS AT YOUR FACILITY IF AVAILABLE.



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DEC 28 2008
BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

GENERAL PHYSICAL EXAM/SYSTEMS REVIEW

DATE OF SERVICE: 4/13/09

PATIENT NAME: Wolfkill, Rebecca

DOB: 2/17/51

SUBJECTIVE FINDINGS:

none

OBJECTIVE FINDINGS: V/S: B/P 124/80 P 68 R 16 TEMP. 96.9

HEIGHT: 5' WEIGHT: 139

a, 0 x 3

CLINICAL FINDINGS:

EENT:

LUNGS:

HEART:

ABDOMEN: ac

EXTREMITIES:

SKIN:

MENTAL/NEURO:

ASSESSMENT/DIAGNOSES: physically fit

PLAN: cont meds for hypothyroidism, hyperlipidemia, hypertension
no need for TB skin tests; chest x-ray 8/8/05 @
no signs of PTD

PHYSICIAN PRINTED NAME: Frances Pence

PHYSICIAN SIGNATURE: [Signature]

RECEIVED
DATE 2009 4/13/09

HEALTH CARDS INTERVIEW FORM

DATE: 8/14/08
NAME: Woffkill, Rebecca
DOB: 2/17/1951
GENDER: female
H/C #: 1378949
COUNTRY OF BIRTH: Phillipines

PPD RESULT: mm (Reactor) (Converter)
X-RAY: SNHD / PRIVATE
COMMENTS: Symptom Review only
NURSE'S SIGNATURE: [Signature]

Have you ever had a TB skin test: Quantiferon blood test _____

If yes, was it Negative or Positive (Circle one) (+) - NO RECORD

When was your last TB skin test and/or Quantiferon blood test 1993-1995?

Do you have:

YES

NO

- 1. Cough lasting three or more weeks
- 2. Coughing up blood
- 3. Unexplained weight loss
- 4. Loss of appetite
- 5. Fever
- 6. Night sweats
- 7. Extreme tiredness/fatigue
- 8. A smoking habit

_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>

Have you been diagnosed with any of the following medical conditions?

- 1. Diabetes
- 2. Lupus Erythematosus
- 3. Rheumatoid Arthritis
- 4. Sarcoidosis
- 5. Kidney failure / Dialysis
- 6. Cancer, Lymphoma or Leukemia
- 7. Chemotherapy
- 8. Organ transplant
- 9. HIV or AIDS
- 10. Blood clotting disorder
- 11. Epilepsy or Seizure disorder
- 12. Liver Disease or Hepatitis
- 13. History of Gastrectomy / Partial stomach removal

_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>
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_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>

If female:

- 1. Are you pregnant
- 2. Are you currently breast feeding

_____	<input checked="" type="checkbox"/>
_____	<input checked="" type="checkbox"/>

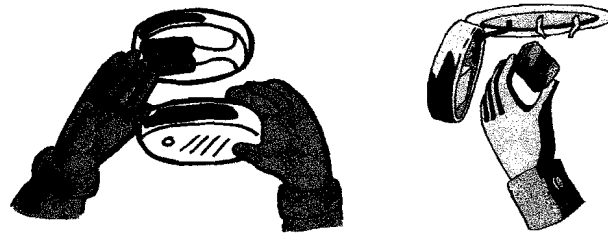
CLIENT'S SIGNATURE Rebecca N. Woffkill

RECEIVED

DEC 22 2008

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Y-444
TAG
12/12/09



Smoke Detector Monthly Inspection Report

Month DECEMBER Day 12 Year 2009

Room	Operational	Needs Repair	Date Repaired
Bedroom #1	/ yes	no	no
Bedroom #2	/ yes	no	no
Bedroom #3	/ yes	no	no
Bedroom #4	/ yes	no	no
Bedroom #5	/)
Laundry	/ yes	no	no
Living Room	/ yes	no	no
Entry	/ yes	no	no
Garage	/ yes	no	no

Adde M. de Guzman
Signature of Person Conducting the Inspection

ADDE M. DE GUZMAN
Print Name Here

RECEIVED
DEC 28 2009
BUREAU OF LICENSURE AND REGULATION
LAS VEGAS, NEVADA

CLAIM FOR REIMBURSEMENT FOR RESIDENTIAL PROGRAMS SERVICE

12/3/09
9-895
FAG-11/1/09

To: Southern Nevada Adult Mental Health Services
6161 West Charleston Boulevard
Las Vegas, NV 89146

For Period: November, 2009

From: Addie's Home Care
7955 Trail Head Dr.
Las Vegas, N.V. 89113

RECEIVED
BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

18-7404 - \$2,652.84
18-7405 - \$767.00

Resident's Name	SSN or DOB	Dates of Service	No. of Days	Facility Care Rate (+)	Stipend Allowance GH (+)	Stipend Allowance Other (+)	Client Revenue (-)	Other Revenue (+)	Balance Owed by Agency (=)
Belinda Watson	530-60-8800	10-1-09/11-30-09	30	1,318.00	143.00	-	855.00	143.00	767.00
Ralph Pheugh	530-08-0540	11-1-09/11-30-09	30	940.00	143.00	-	674.00		409.00
Charles Chirilus	353-60-3736	11-1-09/11-30-09	30	940.00	143.00	-	551.00		532.00
Keith Gresh	211-54-1417	11-1-09/11-30-09	30	940.00	143.00	-	0		1,083.00
Orsha Lyler	601-86-0168	11-18-09/11-20-09	18	345.81	83.00		0		628.81
TOTAL				\$ 4,163.81	\$ 655.03		\$ 1,776.00	\$ 143.00	\$ 3,419.84

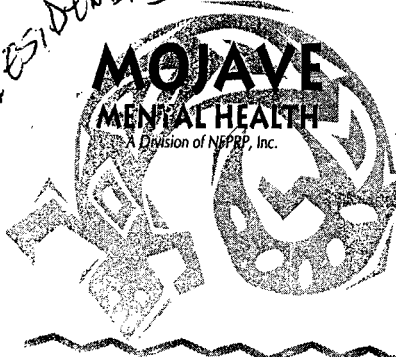
I hereby certify that the above claim is in accordance with the contract between Southern Nevada Adult Mental Health Services and payments agreements for identified residents are complete, signed, and in my possession.

Date: 11/1/09 Signature: Addie M. de Guzman
Facility Administrator or Designee

Date: 12/2/09 Signature: Terri Nanto
Residential Program Director

D/B

RESIDENTIAL



Tag 4-908
12/22/09

JOHN V. ANOOSHIAN, M.D.
Mojave Mental Health
Psychiatric Clinic

4000 East Charleston Blvd., Suite B-130
Las Vegas, Nevada 89104
702 • 968 • 4000
Fax: 968 • 4040

PATIENT INSTRUCTIONS

PATIENT NAME: Rich Pheigh DATE: 12/22/09

1. MEDICATION

① Change Vistaril to 50mg am,
100mg midday, 50mg pm.

2. OTHER

John V. Anooshian, M.D.

Group Care Facility Addies Home Care

Patient Name Watson, Belinda

Medication Sche

Month November

(1) Medication	(2) Taken	(3) Pill	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Phenazone	8 PH	BW	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dosage 5 mg																	
Take one																	
Tab night time																	
(6) Prescription																	
Tamoxifen	8 PH	BW	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dosage 30 mg																	
Take one																	
Cap at bedtime																	
(6) Prescription																	
Clonazepam	8 PH	BW	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dosage 10 mg																	
Take 3 tabs																	
at bed time																	
(6) Prescription																	

(11) Name of Doctor

(12) Med. Clinic Appointment Kept?																	
(13) Injection Received?																	
(14) Was the Dr./RN Courteous?																	

ALLERGIES:

Group Care Facility: Arden Home Care

Patient Name: Walter, Belinda

Medication Schedule

Month: November Y 1

(1) Medication	(2) Taken	(3) Pill	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	1
RX Hydrocodone Dose: 25mg Take 1 Tab daily																		
RX Cephalexin Dose: 500mg Take 1 cap 3 X daily																		
RX Hydroxyzine Dose: 25mg Take 1 cap at bedtime																		
(6) Prescription																		

(11) Name of Doctor

(12) Med. Clinic Appointment Kept?

(13) Injection Received?

(14) Was the D./RN Courteous?

ALLERGIES:

Group Care Facility Cedarlea Home Care

Medication Schedule

Patient Name Knob, Ruth

Month November

(1) Medication	(2) Taken	(3) Pill	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Bx Pariba 300mg Bosage 300mg		8 AM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Take 2 x daily		7 PM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
(6) Prescription																	
Propionidol Dosage 20mg		8 AM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Take 2 Tab																	
8 x day		7 PM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
(6) Prescription																	
Rx Penicillin Dosage 15mg			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Take 1 cap																	
at bedtime		8 PM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
(6) Prescription																	

(11) Name of Doctor

(12) Med. Clinic Appointment Kept?

(13) Injection Received?

(14) Was the Dr./RN Courteous?

ALLERGIES:

Group Care Facility Arden's Home Care

Patient Name Phyllis Ruth

Medication Schedule

Month November Y

(1) Medication	(2) Taken	(3) Pill	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	1
<u>Origanine</u> Dosage <u>100 mg</u>	<u>8 AM</u>	<u>1</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
<u>Take Fluids</u>			<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
<u>Drug Lyms & Drug of mouth</u>	<u>8 AM</u>	<u>2</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
(6) Prescription																		
RX <u>Leodon</u>			<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
Dosage <u>80mg</u>	<u>8 AM</u>	<u>3</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
<u>Take 1 cup of AHARD</u>			<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
<u>2 caps. bedtime 8 PM</u>			<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
(6) Prescription																		
RX																		
Dosage																		
(6) Prescription																		

(11) Name of Doctor

(12) Med. Clinic Appointment Kept?

(13) Injection Received?

(14) Was the Dr./RN Courteous?

ALLERGIES:

ADULT CARE CONNECTIONS
ACKNOWLEDGES THAT THE PERSON NAMED BELOW HAS
COMPLETED THE MEDICATION MANAGEMENT REFRESHER
COURSE APPROVED BY THE



NEVADA STATE HEALTH DIVISION
THE BUREAU OF HEALTH CARE QUALITY &
COMPLIANCE

Reberca Wolfkill

Has successfully passed the approved medication refresher examination
as required by NAC 449.196(3)(b) for Four (4) Continuing Education Hours)

Date Test Taken: November 14, 2009

Date Certificate Expires: November 13, 2012

Theresa Brushfield Cuens

Signature of Proctor

Certificate No. 20091114002
Adult Care Connections
3732 Lone Mesa Drive
Las Vegas, NV 89147

BUREAU OF LICENSING
AND CERTIFICATION
PERSONS OF NV, NEVADA

NOV 16 2009

RECEIVED

11/15/2009 18:06 702--870-3411
ADULT CARE HOME CARE

FEDEX OFFICE 1303

PAGE 01


FROM : BECKY 1

FAX NO. : 6448270

Nov. 15 2009 02:27PM P2

ADDIES Home Care

Rebecca Wolfkill
 participant name



has successfully completed a course in CPR for the
HEALTH CARE
 following standards established by the
 American Heart Association

Nov. 09 Nov. 2011
 issue date recommended renewal

Barbara DeWise
 Instructor Name

This training has been conducted in accordance with National Standards for
 Cardiopulmonary Resuscitation as set forth by JAMA (Journal of American
 Medical Association.) CPR PLUS assumes NO responsibility for how this
 training is applied by the recipient of this card.

3355 W. Spring Mountain Rd. # R, Las Vegas, NV 89102
 PH (702)252-8989 FAX (702)222-0048

Fax Cover Sheet

Date: 11/15/09

To: Connie Johnson

Company: Dept of Health and Human

Services of Health Care Quality & Compliance

Fax: 775-687-6588

From: Addie Home Care

Company:

Tel: Del. (702) 227-1522

775 (702) 683-8486

Number of pages including this one: 10

Comments:

Enclosed is the requirement that was missing in your survey. If some more I miss please call me at (702) 227-1522

9 pages

- Enclosed:
- Receipt of Flu. mask
 - Addie's FBI- negative
 - Sign of rated
 - Rebecca Waefllil
 - Ruth Pheigh

RECEIVED

NOV 14 2009

BUREAU OF INSURANCE AND COMPENSATION

Elmer

*Addies Home Car*NEVADA DEPARTMENT OF PUBLIC SAFETY
CRIMINAL HISTORY RECORDS REPOSITORY
APPLICANT FINGERPRINT RESPONSEADDIES HOME CAR INC
EDILBERTA M DEGUZMAN OR JOSEPH FLINT
7955 TRAIL HEAD DR
LAS VEGAS, NV 89113

REFERENCE

ACCOUNT NUMBER: 881486

DATE FINGERPRINTED: 2008/08/25

APCN:
PS0223370ANAME:
DEGUZMAN, EDILBERTA MDOB:
1938/02/04OCA:
881486

FBI NEGATIVE

A TECHNICAL FINGERPRINT SEARCH OF THE ABOVE INDIVIDUALS FINGERPRINTS WAS PERFORMED THROUGH THE FBI INTEGRATED AUTOMATED FINGERPRINT IDENTIFICATIONS SYSTEM (IAFIS)

PURSUANT TO NRS 179A.210, BASED ON THE INFORMATION RECEIVED FROM THE BACKGROUND CHECK, IT HAS BEEN DETERMINED THAT NO PRIOR CRIMINAL HISTORY INFORMATION EXISTS FOR WHICH NOTICE IS SUBJECT TO RELEASE.

OR

PURSUANT TO NRS 449.188, BASED ON INFORMATION RECEIVED FROM THE BACKGROUND CHECK, IT HAS BEEN DETERMINED THAT, THIS SUBJECT HAS NOT BEEN CONVICTED OF A CRIME LISTED IN NRS 449.188.

THE INFORMATION CONTAINED IN THIS DOCUMENT IS PROVIDED IN ACCORDANCE WITH THE PROVISIONS OF NEVADA REVISED STATUTE (NRS) 179A.180 - 179A.210. THIS RESPONSE IS BASED ON THOSE RECORDS, DATABASES, AND DOCUMENTS AVAILABLE TO THE CENTRAL REPOSITORY OF NEVADA RECORDS CRIMINAL HISTORY AT THE TIME THE BACKGROUND CHECK WAS PERFORMED. THE INFORMATION IN THIS DOCUMENT SHOULD NOT BE CONSTRUED TO PRECLUDE THE EXISTENCE OF A CONVICTION RECORD OR ADDITIONAL RECORDS OF THE TYPES LISTED IN NRS 179A.190 WHICH MAY BE IN A RECORD, DATABASE OR DOCUMENT NOT AVAILABLE OR ACCESSIBLE BY THE CENTRAL REPOSITORY. USE OF THIS INFORMATION IS REGULATED BY LAW. IT IS PROVIDED FOR OFFICIAL USE ONLY AND MAY BE USED ONLY FOR THE PURPOSE REQUESTED. DISSEMINATION TO A SECOND PARTY OR ENTITY IS PROHIBITED.
REVISED 062608

DATE REPORT GENERATED: 2008/12/17

NEVADA DEPARTMENT OF PUBLIC SAFETY
RECORDS AND IDENTIFICATION BUREAU

ADDIES HOME CARE

RED ROCK MEDICAL CENTER

5701 W Charleston Blvd # 100, Las Vegas, NV 89146.

Phone: (702) 877-9514

211250 DEGUZMAN CESAR M 05/18/1974 11/09/2009 CXR

X-Ray Chest PA & Lateral view.

Both lung fields are clear.

Both apices and CP angles are clear.

Both diaphragmatic contours are normal.

Cardiac shadow within normal limits.

Soft tissues and rib cage do not reveal any abnormality.

The pre & retro-cardiac spaces are clear on Lateral view.

No e/o mediastinal mass.

OPINION:- NORMAL FINDINGS.RD PRABHU
s/d R.D.Prabhu M.D.

ADDIES HOME CARE



Eight Tower Bridge
161 Washington Street - Suite 1400
Conshohocken, PA 19428
TakeCareHealth.com • 1-866-Take-Care (1-866-825-3227)

Tuberculosis Skin Test Results

Patient Name: Cesar Deguzman

Patient DOB: 05-18-1974

Date TB test administered: 11.03.09

Date TB test read: 11.06.09

Take Care Provider Reading Test: M. LePrest PA-C

Result of TB test: ~ 25 mm (Positive/Negative)

Additional Comments: CXR needed. Patient referred to Clark County Health District - TB Clinic. Can also see PCP.

I understand that the results of the Tuberculosis Test. The Take Care Provider has provided me with clear discharge instructions and I acknowledge that I am responsible for adhering to these discharge instructions.

X Cesar Deguzman
Signature of Patient Receiving TB Test (or parent/guardian)

11/6/09
Date

M. LePrest PA-C
Signature of Take Care Provider reading TB Test

11/6/09
Date

Addies Home Care

CVS/pharmacy
for all the ways you care

4014 S. RAINBOW, LAS VEGAS, NV
(702) 873-5917

REG#01 TRAN#8019 CSHR#803119 STR#8809

ExtraCare Card #: *****2121

Large Paper Towel 3338		6.70T
1	N95 FLU MASK 1CT	2.99T
1	N95 FLU MASK 1CT	2.99T
1	N95 FLU MASK 1CT	2.99T

4 ITEMS

SUBTOTAL	15.76
NV 8.1% TAX	1.28
TOTAL	17.04
DEBIT	17.04
*****9546	MS
CHANGE	.00



2508 8099 3148 0190 10
RETURNS WITH RECEIPT THRU 01/09/2010

NOVEMBER 10, 2009 11:19 AM

EARN 2% BACK ON ALMOST EVERYTHING
IN THE STORE AND ON CVS.COM WHEN YOU
USE YOUR EXTRACARE CARD.

THANK YOU. SHOP 24 HOURS AT CVS.COM

ExtraCare Card balances as of 10/11

FALL 2009 SPENDING: 8.47

2009 CVS BRAND SAVINGS: 5.89

save money. earn rewards. see back for details. save money. earn rewards. see back for details. save money. earn rewards. see back for details.

FROM : BECKY 1

FAX NO. : 6448270

Nov. 10 2009 12:46PM P1

ADDIES HOME CARE

Health Form 101

Prior to Admission/Annual TB Symptoms Check

Date of Screening 11/10/09

Name of person being screened REBECCA WOLFKILL (please print)

Your history indicates that you are a tuberculin skin test reactor. People with latent TB infection may develop active TB disease in their lifetime. Please answer the following questions honestly, to help determine if you have symptoms of active TB which may require immediate treatment.

Do you have or have you been experiencing the following?

- 1. A cough that lasts longer than 3 weeks
if yes, when did it start? _____ yes___ no
 - 2. A productive cough
if yes, when did it start? _____ yes___ no
 - 3. Blood in sputum
if yes, for how long? _____ yes___ no
 - 4. Fever (not associated with cold, flu or other apparent illness) yes___ no
 - 5. Sweating at night
if yes, how long have you been experiencing this? _____ yes___ no
 - 6. Unexplained weight loss
if yes, how much weight have you lost? _____ yes___ no
-
- 7. Been in close contact with a person who has active tuberculosis yes___ no

Have you consulted a medical professional for any of these symptoms? yes___ no

if yes, please indicate the name of the medical professional _____

the medical professional's telephone number 243-8436

What medications are you currently taking?

LIPITOR

BENECAE

If it is determined that you answered yes to question number 1 and there are any other yes answers to questions 2-7 and the person being screened has not consulted a medical professional, then a medical professional must be consulted. If the person conducting the screening is a medical professional, then the medical professional should make a determination concerning the disposition of the person being screened.

Name of the Screener SARAM FREEMAN (please print)

Signature of the Screener Saram Freeman Title RN

ADDIES HOME CARE

# Days in Residential Programs	Regular Total w/Stipend	Regular Total w/o Stipend	Regular Client Stipend	Special Needs total w/Stipend	Special Needs total W/oStipend	Special Needs Client Stipend
1	\$ 34.93	\$ 30.32	\$ 4.61	\$ 47.12	\$ 42.51	\$ 4.61
2	\$ 69.87	\$ 60.64	\$ 9.23	\$ 94.26	\$ 85.03	\$ 9.23
3	\$ 104.80	\$ 90.96	\$ 13.84	\$ 141.39	\$ 127.55	\$ 13.84
4	\$ 139.74	\$ 121.29	\$ 18.45	\$ 188.51	\$ 170.06	\$ 18.45
5	\$ 174.67	\$ 151.61	\$ 23.06	\$ 235.64	\$ 212.58	\$ 23.06
6	\$ 209.61	\$ 181.93	\$ 27.68	\$ 282.78	\$ 255.10	\$ 27.68
7	\$ 244.55	\$ 212.26	\$ 32.29	\$ 329.90	\$ 297.61	\$ 32.29
8	\$ 279.48	\$ 242.58	\$ 36.90	\$ 377.03	\$ 340.13	\$ 36.90
9	\$ 314.42	\$ 272.90	\$ 41.52	\$ 424.16	\$ 382.64	\$ 41.52
10	\$ 349.35	\$ 303.22	\$ 46.13	\$ 471.29	\$ 425.16	\$ 46.13
11	\$ 384.29	\$ 333.55	\$ 50.74	\$ 518.42	\$ 467.68	\$ 50.74
12	\$ 419.22	\$ 363.87	\$ 55.35	\$ 565.54	\$ 510.19	\$ 55.35
13	\$ 454.16	\$ 394.19	\$ 59.97	\$ 612.68	\$ 552.71	\$ 59.97
14	\$ 489.10	\$ 424.52	\$ 64.58	\$ 659.81	\$ 595.23	\$ 64.58
15	\$ 524.03	\$ 454.84	\$ 69.19	\$ 706.93	\$ 637.74	\$ 69.19
16	\$ 558.97	\$ 485.16	\$ 73.81	\$ 754.07	\$ 680.26	\$ 73.81
17	\$ 593.90	\$ 515.48	\$ 78.42	\$ 801.19	\$ 722.77	\$ 78.42
18	\$ 628.84	\$ 545.81	\$ 83.03	\$ 848.32	\$ 765.29	\$ 83.03
19	\$ 663.78	\$ 576.13	\$ 87.65	\$ 895.46	\$ 807.81	\$ 87.65
20	\$ 698.71	\$ 606.45	\$ 92.26	\$ 942.58	\$ 850.32	\$ 92.26
21	\$ 733.64	\$ 636.77	\$ 96.87	\$ 989.71	\$ 892.84	\$ 96.87
22	\$ 768.58	\$ 667.10	\$ 101.48	\$ 1036.83	\$ 935.35	\$ 101.48
23	\$ 804.32	\$ 697.42	\$ 106.10	\$ 1083.97	\$ 977.87	\$ 106.10
24	\$ 838.45	\$ 727.74	\$ 110.71	\$ 1131.10	\$ 1020.39	\$ 110.71
25	\$ 873.38	\$ 758.06	\$ 115.32	\$ 1178.22	\$ 1062.90	\$ 115.32
26	\$ 908.33	\$ 788.39	\$ 119.94	\$ 1225.36	\$ 1105.42	\$ 119.94
27	\$ 943.26	\$ 818.71	\$ 124.55	\$ 1272.49	\$ 1147.94	\$ 124.55
28	\$ 978.19	\$ 849.03	\$ 129.16	\$ 1319.61	\$ 1190.45	\$ 129.16
29	\$1013.12	\$ 879.35	\$ 133.77	\$ 1366.74	\$ 1232.97	\$ 133.77
30	\$1048.06	\$ 909.67	\$ 138.39	\$ 1413.87	\$ 1275.48	\$ 138.39
31	\$1083.00	\$ 940.00	\$ 143.00	\$ 1461.00	\$ 1318.00	\$ 143.00

AGNES P. MORTEL, MD
5025 Alta Drive Las Vegas, Nevada 89107

Tuberculin Skin test (Mantoux)

Patient name: Rioh Pheigh SSN: _____

First step

Date given: 9/25/09 Site: ② FA Size: _____

Induration: 0 mm Date read: 10/2/09

Manufacturer: JHP Lot: 111057

Expiration: 11/10 Administered by: [Signature]

Second step

Date given: 10/5/09 Site: ② FA Size: _____

Induration: 0 mm Date read: 10/8/09

Manufacturer: JHP Lot: 111057

Expiration: 11/10 Administered by: [Signature]