

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2016AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2009
NAME OF PROVIDER OR SUPPLIER CARING HEARTS CARE HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 64 NORTH PEARL STREET LAS VEGAS, NV 89110		
(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 Surveyor: 27364 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 at your facility on 12/16/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for ten 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 nine. Nine resident files were reviewed and six employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 693 SS=D	449.2712(2) Oxygen-Caregiver monitor resident ability NAC 449.2712 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which	Y 693		

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 693	Continued From page 1 necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 12/16/09, the facility failed to ensure oxygen tanks were secured in a rack or to the wall in 1 of 5 resident rooms that utilized oxygen (bedroom #1). Severity: 2 Scope: 1	Y 693		
Y 878 SS=E	449.2742(6)(a)(1) Medication / Change order	Y 878		

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Y 878	Continued From page 2 NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a 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: Surveyor: 27364 Based on record review and interview on 12/16/09, the facility failed to ensure that 3 of 9 residents received medications as prescribed (Resident #1, #3, and #9). Findings include: Resident #1 was prescribed: *Atropine 1% eye solution 2 drops every 2 hours as needed (PRN). The medication was not available in the facility. Employee #4 stated the medication expired and was destroyed. Resident #3 as prescribed: *Hydrocodone APAP 5/500 milligrams (mg) one tablet every 6 hours PRN. The medication was not available in the facility. Resident #9 was prescribed: *Albuterol .83% mg/milliliter one unit dose vial SVN every 4 hours PRN. The medication was	Y 878		

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Y 878	Continued From page 3 not available in the facility. Severity: 2 Scope: 2	Y 878		

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