

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5422AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2011
NAME OF PROVIDER OR SUPPLIER CANYON HILLS MANOR II		STREET ADDRESS, CITY, STATE, ZIP CODE 4540 S MONEY ST PAHRUMP, NV 89048		
(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 a complaint investigation conducted in your facility from 10/3/11 through 10/18/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. Complaint #NV00029498 was substantiated. See TAGs Y0050, Y0878, Y0920, and Y0922.	Y 000		
Y 050 SS=D	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS.	Y 050		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 050	Continued From page 1 This Regulation is not met as evidenced by: Based on interview, record review and observation on 10/3/11 to 10/18/11, the administrator failed to provide oversight and direction to the staff to ensure 1 of 5 residents receive the needed services and protective supervision they required. This was a repeat deficiency from the 6/21/10 State Licensure survey. Findings include: Three hospice employees stated that the facility failed to allow hospice employees into the facility to care for Resident #5. Missed Visit/Refused Service reports documented that the facility would not allow hospice nursing assistants into the facility to see Resident #5 on 9/9/11, 9/16/11, 9/21/11, 9/22/11, and 9/23/11. Employee #3 stated that hospice staff were denied access due to their failure to leave care notes at the facility. Severity: 2 Scope: 1	Y 050		
Y 878 SS=E	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this	Y 878		

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Y 878	<p>Continued From page 2</p> <p>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:</p> <p>(a) The caregiver responsible for assisting in the administration of the medication shall:</p> <p>(1) Comply with the order.</p> <p>This Regulation is not met as evidenced by: Based on record review and interview from 10/3/11 to 10/13/11, the facility failed to ensure 1 of 5 residents received medications as prescribed (Resident #5).</p> <p>Findings include:</p> <p>Pill counts conducted by a home health agency documented that Resident #5 had missed three to five doses of medications from 9/5/11 through 9/12/11. The hospice agency also reported on 9/12/11 that when the hospice nurse requested to see the resident's Medication Administration Record (MAR), Employee #1 initialed the blank areas of the MAR prior to handing the MAR to the hospice nurse.</p> <p>The pill counts conducted on 9/5/11, 9/12/11, and 9/19/11 documented that Resident #5 was not given his medications as prescribed for three to five days between 9/5/11 and 9/12/11. Specifically:</p> <p>- The count for aspirin was 21 pills on 9/5/11, and 18 pills on 9/12/11 and the count should have been 14 pills.</p>	Y 878		

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Y 878	Continued From page 3 - The count for Tizanidine was pills on 9/5/11, and 17 pills on 9/12/11 and the count should have been 15 pills. - The count for Benazepril was 15 pills on 9/5/11, and 13 pills on 9/12/11 and the count should have been 8 pills. - The count for Levothyroxine was 111 pills on 9/5/11, and 109 pills on 9/12/11, and the count should have been 104 pills. Severity: 2 Scope: 2	Y 878		
Y 895 SS=C	449.2744(1)(b)(1) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician.	Y 895		

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Y 895	Continued From page 4 This Regulation is not met as evidenced by: Based on record review on 10/3/11, the facility failed to ensure the medication administration record (MAR) was accurate for 2 of 5 residents (Resident #2, and #3). Findings include: - Medication Administration Records (MAR) for Resident #2 were not initialed for Simvastatin, 40 milligrams, 1/2 tablets at bedtime for the dose on 10/2/11. - The MAR for Resident #3 who was prescribed Seroquel 300 milligrams, one tablet at bedtime and Risperidone, 2 milligrams, one tablet at bedtime was not initialed for the dosages that should have been given on 10/2/11. Employee #1 stated that other staff gave the medication but forgot to initial the MARs on 10/2/11. Severity: 1 Scope: 2 This was a repeat deficiency from the survey conducted on 6/21/10.	Y 895		
Y 920 SS=F	449.2748(1) Medication Storage NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential	Y 920		

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Y 920	Continued From page 5 facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. This Regulation is not met as evidenced by: Based on observation on 10/3/11, the facility failed to ensure medications belonging to an employee were kept in a locked container (Employee #2 was maintaining three bottles of his personal medications in room #2 which was left unlocked). Severity: 2 Scope 3	Y 920			
Y 922 SS=C	449.2748(3)(a) Medication Labeling NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be:	Y 922			

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Y 922	Continued From page 6 (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician. This Regulation is not met as evidenced by: Based on observation on 9/3/11, the facility failed to ensure medications were plainly labeled for 1 of 5 residents (Resident #2, over the counter Duosate Sodium and Bayer Aspirin were not labeled with the resident's name and dosage). Severity: 2 Scope: 1	Y 922		

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