

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS121AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/11/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>CONCORDE ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2465 E TWAIN AVE LAS VEGAS, NV 89121</b>		
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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 on 5/11/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 73 Residential Facility for Group beds for elderly and disabled persons, Category II residents.  Complaint #NV00021554 was substantiated. See Tags Y050 and Y590.	Y 000		
Y 050 SS=G	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	<p>Continued From page 1</p> <p>This Regulation is not met as evidenced by: Based on interview, record review and observation on 5/11/09, the administrator failed to provide oversight and direction to the staff to ensure 2 of 73 residents receive the needed services and protective supervision they required.</p> <p>Findings include:</p> <p>Resident #1 reported she noticed Resident #2 acting aggressively toward while eating lunch in the dining room on 3/24/09. Resident #2 sat at a table next to Resident #1's table. Resident #1 reported Resident #2 was making a fist with one of her hands and was shaking it at her while talking loudly.</p> <p>Resident #1 stated she reported this event to the facility administrator in his office after lunch. She related that the administrator told her he would have one of the staff talk to Resident #2 to find out why she was upset.</p> <p>Resident #1 reported that she was eating dinner at her table with her table mate that evening. She stated she heard Resident #2 yelling at her and when she turned toward Resident #2, the resident had left her table and was coming toward Resident #1. Resident #1 related that Resident #2 grabbed the neckline of her dress on her left side and was pulling on it. Resident #1 stated she brought her right arm across her body to push the other resident away and Resident #2 grabbed her right forearm. Facility staff was able to pull Resident #2 away from Resident #1 and take her out to the hallway.</p> <p>The staff reports dated 3/24/09 related the same</p>	Y 050		

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Y 050	Continued From page 2  incident between Resident #1 and #2. One staff member also wrote that when Resident #2 was out in the hallway she said she was upset at the women at Resident #1's table because they were saying mean things about her. Two staff members wrote that Resident #2 was so mad she ripped open her blouse and was standing in the hallway topless. Staff was able to get Resident #2 to her room to change her shirt and she was given an "as needed" medication Alprazolam (Xanax).  The facility nurse documented in Resident #2's file on 3/24/09 that the resident's Power of Attorney was called but could not be reached. The police were also called to the facility. The police interviewed the resident and decided to have her transported to the hospital for a mental evaluation. An evaluation was done by the resident's physician on 3/25/09. On 3/26/09, the hospital reported the resident's cardiac enzymes were elevated indicating the resident was having a heart attack. On 4/1/09, the hospital was ready to discharge the resident back to the facility and the facility declined the placement due to her aggressive behavior. The facility nurse reported she was informed Resident #2 recently died.  On 5/11/09, the administrator reported Resident #1 came to his office in the early afternoon on 3/24/09 and make a report about Resident #2. He related that Resident #1 demonstrated how Resident #2 made a fist and shook it at her. He stated that he told Resident #1 he would have one of his staff members go to Resident #2 and talk to her. The administrator admitted he was called away from the facility before he talked to any of his staff about Resident #1's concerns. The altercation between Resident #1 and #2 occurred later that day during the dinner meal.	Y 050		

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Y 050	Continued From page 3	Y 050		
Y 590 SS=G	<p>Due to the inaction of the administrator, Resident #1's right arm was bruised during the altercation with Resident #2. His inaction also led to a delay in Resident #2 receiving a evaluation for a change in behavior.</p> <p>Severity: 3 Scope: 1</p> <p>449.268(1)(a) Resident Rights</p> <p>NAC 449.268 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility.</p> <p>This Regulation is not met as evidenced by: Based on observation, interview and record review on 5/11/09, the facility administrator failed to ensure 1 of 73 residents was not abused by another resident of the facility (Resident #1).</p> <p>Findings include:  See Tag Y050.</p> <p>Resident #1 is a 71-year old female who was admitted to the facility on 9/6/04. The resident has diagnoses of coronary artery disease, high blood pressure, non-insulin dependent diabetes and anxiety. The resident lives in the facility as an independent resident and is able to manage</p>	Y 590		

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Y 590	<p>Continued From page 4</p> <p>her medications and self care.</p> <p>Resident #2 was a 78-year old female who was admitted to the facility on 10/1/07. The resident had diagnoses of high blood pressure and dementia, and a history of a stroke. The resident lived in the facility as a resident who required assistance with her personal care and medications.</p> <p>Review of care notes in Resident #2's file revealed the resident showed aggressive behavior on 5/13/08 toward the facility's nurse. The Licensed Practical Nurse (LPN) wrote that Resident #2 was very angry and agitated with her because she made an appointment for the resident to go see her doctor. The LPN documented the resident was following her around and telling the LPN that she would kill her in the parking lot. The LPN noted that there were no "as-needed" (PRN) medications available for this resident for agitation. The LPN indicated she left messages for the resident's doctor requesting PRN medications because the resident "striking out."</p> <p>It was noted on a Medication Order form dated 6/25/08 that Resident #2 was prescribed Alprazolam (Xanax) 0.25 mg, one table two times a day as needed. Xanax is a medication used for anxiety.</p> <p>Resident #2 had a physical on 6/25/08 and her physician listed her primary diagnosis as dementia and her secondary diagnosis as high blood pressure. The physician indicated that an appropriate level of residential care for Resident #2 would be an Alzheimer's/dementia care facility. Concorde Assisted Living is not licensed as a dementia care facility.</p>	Y 590		

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Y 590	<p>Continued From page 5</p> <p>The doctor for Resident #2 also wrote note to the director of nursing for Concorde Assisted Living on 6/25/08 relating that the resident was in to see him that day, that the resident has dementia and has difficulty expressing herself. The doctor requested that the facility have somebody accompany the resident to her future appointments and to bring a list of her medications.</p> <p>Interviews and record reviews conducted on 5/11/09 revealed the administrator of the facility was informed by Resident #1 that Resident #2 had been making aggressive gestures and comments toward her in the dining during the noon meal on 3/24/09. The administrator told Resident #1 that he would have his staff intervene and evaluate Resident #2's change in behavior toward Resident #1. The administrator left the facility that afternoon without discussing the situation with his staff.</p> <p>Later on 3/24/09, during the evening meal, Resident #2 became verbally and physically aggressive with Resident #1. Resident #2 grabbed and pulled on the neckline of Resident #1's dress, and grabbed the arm of Resident #1 when Resident #1 tried to push Resident #2 away. Dining room staff were able to remove Resident #2 from the dining room and take her to her room. Resident #1 had redness and swelling to the right forearm, and though an ice pack was applied, this resulted in bruising on the arm.</p> <p>The facility administrator failed to prevent Resident #2 from abusing Resident #1.</p> <p>Severity: 3 Scope: 1</p>	Y 590		

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