Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 04/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(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 on 4/7/10 to 4/9/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 150 total beds, 120 elderly or disabled persons, and/or persons with mental illnesses, and/or persons with chronic illnesses, and 30 persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 62. Fifteen resident files were reviewed. Complaint #NV00024991 was substantiated. See Tags Y050 and Y590.	Y 000		
Y 050 SS=H	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		

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 050	Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review on 4/7/10 to 4/9/10, the administrator failed to provide oversight and direction to the staff to ensure 1 of 4 residents received the needed services and protective supervision they required (Resident #1). Findings include: The administrator failed to ensure Residents #1 received assistance with obtaining needed medication to prevent hospitalization (Refer to TAG Y590). Severity: 3 Scope: 2	Y 050		
Y 590 SS=H	449.268(1)(a) Resident Rights 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. This Regulation is not met as evidenced by: Based on record review and interviews from	Y 590		

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Y 590	Continued From page 2 4/7/10 to 4/9/10, the administrator failed to ensure staff met the needs of 1 of 4 residents who were assisted by the facility with obtaining their medications for self administration (Resident #1) . Findings include: Resident #1 was transferred from a convalescent hospital and admitted to the facility on 8/31/09. The resident's file contained a pre-admission physician's Physical and History dated 8/25/09 that indicated the resident was diagnosed with bilateral lower extremity deep venous thromboses (DVT) that was treated with Coumadin, hypothyroidism, debility and depression. Pre-admission paperwork completed by the discharging convalescent hospital listed the following as medications currently being taken by the resident: - Prozac 20 milligrams (mg), one time a day (anti-depressant) - Wellbutrin 100 mg, two times a day (anti-depressant) - Levothyroxine 75 mcg, one time a day (thyroid) - Metoprolol 25 mg, one time a day (blood pressure/anti-hypertensive) - Coumadin 4 mg, at bedtime (blood thinner) - Phenergan 12.5 mg, as needed (PRN) every 6 hrs (antihistamine) - Restoril 15 mg, at bedtime (sedative). Resident #1's pre-admission, physician exam and residential facility admission documents all listed the resident's seven prescribed medications and were located in the resident's facility file. The facility added over-the-counter medications Tylenol, Tums, Dolax suppositories and Milk of Magnesia. Facility admission records dated 8/31/09 documented under "Medical Services	Y 590		

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Y 590	Continued From page 3	Y 590		

Needed/Receiving" that the resident did not need any assistance except with obtaining prescriptions for medications for self administration. It was noted in the resident's file that she received a prescription from another physician for Percocet (pain) on 9/7/09.

On 3/31/10, facility staff documented that Resident #1 complained of "heavy pain in her thighs that had been going on for hours." Staff noted the facility physician was notified and the resident requested to be transferred to a hospital. Resident #1 was admitted to the hospital emergency room with complaints of right lower extremity and left lower extremity pain that started during the night. A hospital ultrasound showed deep vein thrombosis (DVT) in the superficial femoral and popliteal veins bilaterally. The hospital treated the resident with Coumadin.

Resident #1 was interviewed in the hospital on 4/7/10 and 4/8/10. The resident related that when she was admitted to the hospital she had so much pain in her legs she had to scream. The resident reported she believed she was in the hospital because she did not have access to Coumadin for the past three or four months. She stated that on admission to the residential facility, the facility agreed to order refills of her medications and that she would pay for the pharmacy service. The resident reported when she was admitted to the facility she gave the Wellness Director, Employee #2, the sheet listing her seven prescribed medications. The Wellness Director, a registered nurse, told her the list of medications would be given to the physician to be ordered; the physician would write the prescriptions and give them to the facility; the facility would contact the pharmacy in Utah; and the resident's account would be charged for the

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Y 590	Continued From page 4 delivered medication. Resident #1 reported that she met with the facility's physician who made "house calls" at the facility. She said that the physician had the list of her medications in his hand during their visit. The resident reported that when the medications she had brought from the convalescent hospital ran out, she expected the facility doctor would write new orders and the facility would refill all her prescriptions. The facility had documented that the Wellness Director faxed a request to the facility's contract pharmacy on 11/10/09 with the prescriptions for Resident #1 from the physician for Hydrocodone (pain), Levothyroxine (thyroid) and Prozac (anti-depressant). Resident #1 reported that when staff delivered only three medications, she asked why she was not getting all the medications that were on her admission list. The resident said she was told by the Wellness Director and caregivers that the facility's physician only wrote orders for two of the original prescriptions (Levothyroxine and Prozac) and the pain medication. The resident stated she continued to ask caregivers why she was no longer getting Coumadin and she was told the physician had not written an order for it. Resident #1 related that after getting no help from staff to find out why the facility physician had not written orders for her Coumadin, Wellbutrin, Metoprolol, Phenergan and Restoril, she thought maybe she was getting better and the facility doctor did not think she needed the medications any longer. The resident expressed frustration because the faciltity deducted $200 from her account to pay the facility doctor for writing only three presciptions plus $71.00 for the prescriptions.	Y 590		

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Y 590	Continued From page 5 The Wellness Director was interviewed on 4/7/10. The Wellness Director reported that Resident #1 saw the facility's physician in November 2009 and she did not know why the physician ordered only three of the resident's medications. The Wellness Director was shown that the facility documented in the resident's file that she had a history of DVT and was being treated with Coumadin when admitted to the facility. When asked why Resident #1 did not receive Coumadin, the Wellness Director shrugged her shoulders and said "I have no idea why she didn't get the Coumadin." Facility failed to provide protective oversight for Resident #1 which resulted in a hospital admission on 3/31/10. The facility did not provide evidence that it attempted to clarify Resident #1's medication orders with the facility physician after multiple inquiries by the resident, or request that the facility's physician re-fill Resident #1's medications. The facility did not assist Resident #1 with obtaining previously prescribed medications for high blood pressure (Metoprolol), depression (Wellbutrin), possible allergies (Phenergan), a sleep aid (Restoril) or bilateral lower extremity deep venous thromboses (Coumadin). Severity: 3 Scope: 2	Y 590		