DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN MANOR GROUP HOME	**6165 DUNCAN DRIVE, LAS VEGAS, NEVADA ,89108**

(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) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 07/30/2020, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was five. The sample size was four. One complaint was investigated. Complaint #61258 with four allegations was unsubstantiated. Allegation #1 - Staff dragged a resident across the floor. Allegation #2 - Failure to report alleged abuse to appropriate agencies. Allegation #3 - Resident privacy not protected and was only allowed to use a speaker phone. Allegation #4 - A resident's spouse was not allowed to remove resident from the facility. The investigation into the allegations included: Observations of care provided to residents; and staff interactions with residents. Interviews with staff, administrator, four current residents, the resident of concerns and the spouse. Record review/clinical record review of five resident files including resident of concern, discharge policy, discharge plan documentation, incident reports, communication policy, policy for reporting suspected abuse, facility general rules, three staff files and elder abuse training certificates. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.