STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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 State Licensure annual survey conducted in your facility on 02/26/19. This State Licensure survey was conducted by in accordance with Chapter 449, Residential Facility . The facility received an annual survey grade of D. The census at the time of survey was four. Four sample resident files were reviewed and four employee files were reviewed. The findings and conclusions of any investigation by the Division of Public and Behavioral Health 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. The following deficiencies were identified:	0000		
0177 SS= F	449.209(4)(d) - Health and Sanitation-Dirt, Garbage, Refuse - NAC 449.209 Health and sanitation. 4. To the extent practicable, the premises of the facility must be kept free from: (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview the facility failed to ensure there was no accumulation of dust and dirt. Findings include: On 02/25/19 at 8:50 am, dust and dirt were noted throughout the kitchen on countertops, in cabinets and on the floor. Large chunks of dirt were removed from the drawer below the oven. A Caregiver confirmed the kitchen needed to be cleaned. On 02/25/19 at 9:20 am, large amounts of dust were noted in the living room on window ledges, a ceiling fan, an organ and a table. A Caregiver confirmed the living room needed to be cleaned. On 02/25/19 at 9:40 am, a hanging lamp above the kitchen table and adjacant window ledges had large amounts of dust on them. A Caregiver confirmed there was dust on these surfaces. Scope: 3 Severity: 2	0177	A) Immediately after the inspection conducted on 2/25/19; Administrator ordered a general cleaning of facility's kitchen area; specifically the countertops; cabinets; floor; oven; hanging lamp; window edges in the dining room; and the ceiling fan; organ; a table and window edges in the living room as evidenced of exhibit "A" TAG Y 0177; exhibit "A-1" TAG Y 0177; exhibit "A-2" TAG Y 0177; exhibit "A-3" TAG Y 0177; exhibit "A-4" TAG Y 0177; exhibit "A-5" TAG Y 0177; exhibit "A-6" TAG Y 0177; exhibit "A-7" TAG Y 0177; exhibit "A-8" TAG Y 0177; exhibit "A-9" TAG Y 0177; exhibit "A-10" TAG Y 0177. B) Administrator should randomly check kitchen area; it's equipment; surroundings and make sure it is always free from dust, dirt and well kept; so with the living room area keeping it tidy and clean. C) Monitor for Compliance. D) Person Responsible: Administrator E) Completion Date : 03/10/2019	03/10/2019

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARIA T ACOBA Title: Administrator Date: 03/12/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0178 SS= D	449.209(5) - Health and Sanitation-Maintain Int/Ext - NAC 449.209 Health and sanitation. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the backyard is free of garbage and debris. Findings include: On 02/25/19 at 9:30 AM, a broken bed frame and pieces of scrap wood were noted in the backyard near a storage shed. On 01/10/19 at 3:45 PM, a Caregiver indicated the bed frame had been there for a week and was going to be removed by maintenance. The Caregiver confirmed the bed frame and debris should not be there and needed to be removed. Scope: 1 Severity: 2	0178	A) On 2/27/2019; Administrator ordered the disposal of the bed frame and some debris that were sitting at the backyard near the storage shed. Hereto attached is exhibit "B" TAG Y 0178 evidencing the clean up that was done. B) Administrator should inspect the facility's premises regularly and make sure that the interior and exterior landscaping is well kept and maintained. C) Monitor for Compliance D) Person Responsible: Administrator E) Completion Date: 2/27/2019	02/27/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0250 SS= F	449.217(1) - Kitchens-Equipment works; Clean and Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation and interview, the facility failed to ensure the food preparation area was clean to allow for sanitary preparation of food. Findings include: On 02/25/19 at 8:50 am, food debris was noted in the oven, the refrigerator, the freezer, in cabinets on shelves and on countertops. A Caregiver indicated the kitchen is cleaned daily. A Caregiver confirmed the kitchen needed to be cleaned. On 02/25/19 at 8:51 am, a bottle of Sweetened Chili Sauce, inside a cabinet below the oven, leaked all over the cabinet and other food items. On 02/25/19 at 8:55 am, the kitchen had multiple cabinet doors and handles covered in grease. On 02/25/19 at 8:56 am, a Caregiver indicated the kitchen was cleaned daily. A Caregiver confirmed the cabinets were sticky with grease and needed to be cleaned. Scope: 3 Severity: 2	0250	A) A general cleaning of the kitchen countertops; oven; refrigerator; cabinets and shelves was ordered by the Administrator as evidenced of exhibit "C" TAG Y 0250; exhibit "C-1" TAG Y 0250; exhibit "C-2" TAG Y 0250; exhibit "C-3" TAG Y 0250; exhibit "C-4" TAG Y 0250; exhibit "C-5" TAG Y 0250; exhibit "C-6" TAG Y 0250; exhibit "C-7" TAG Y 0250; exhibit "C-8" TAG Y 0250; exhibit "C-9" TAG Y 0250; exhibit "C-10" TAG Y 0250 and exhibit "C-11" TAG Y 0250 respectively. B) Inspection of the kitchens storage, equipments should be one everyday to maintain a clean and sanitary area for the preparation of food. C) Administrator should monitor for compliance. D) Person Responsible : Administrator E) Completion Date: 02/28/2019	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0252 SS= E	449.217(3) - Storage of Food-Adequate storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation and interview the facility failed to properly label and store food items. Findings include: On 02/25/19 at 8:50 am, multiple items in kitchen cabinets were unlabeled and unidentifiable as to what they were. Soy sauce was stored in a coffee jar in a cabinet below the oven. A Caregiver confirmed it should not be stored this way. On 02/25/19 at 8:52 am, Garlic cloves that should be refrigerated were stored in a bowl in a kitchen cabinet. A Caregiver confirmed these garlic cloves should be refrigerated. On 02/25/19 at 8:54 am, a slice of pizza was noted inside an oven that was turned off. A Caregiver indicated it belonged to another staff member and was there for three days. On 02/25/19 at 8:57 am, multiple unlabled styrofoam items and bowls with plates on them were noted in refrigerator. A Caregiver indicated the items in styrofoam were for an meal but could not confirm what was in the bowls covered by lids but indicated it food items that belonged to staff. A Caregiver confirmed the staff have their own refrigerator so they were unsure why these items were in the resident's refrigerator. Scope: 2 Severity: 2	0252	A) Administrator ordered the labeling of all items inside the refrigerator; kitchen cabinets evidencing exhibit "D" TAG Y 0252; photo of the inside of the refrigerator; exhibit "D-1" TAG Y 0252 and exhibit "D-2" TAG Y 0252 respectively evidencing under the stove cabinets . B) Administrator should conduct a regular inspection of the refrigerator; kitchen cabinets; oven and see to it that all items found therein not in there original container are labelled so with all left over foods. C) Monitor for Compliance. D) Person Responsible: Administrator E) Completion Date: 02/26/2019	02/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0272 SS= C	449.2175(3) - Service of Food - Menus - NAC 449.2175 Service of food; seating; menus; special diets; nutritional requirements; dietary consultants. 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. Inspector Comments: Based on observation and interview the facility failed to provide a dining menu to 4 of 4 residents. Findings include: On 02/25/19 at 9:58, the dining menu for the month of February was hung on a board in a living room not used by residents. On 02/25/19 at 10:50 am, Resident #1 indicated they do not know what food was served until mealtime. On 02/25/19 at 2:25 pm, Resident #3 indicated a menu was not provided to the residents. On 02/25/19 at 2:43 pm, the administrator confirmed the menu was not provided to the residents. Scope: 2 Severity: 1	0272	A) A copy of the weekly menu was posted in the dining room area visible for the resident to see and copies of menus was ordered by the Administrator to be given to the residents every week. Exhibit "E" TAG Y 0272 is hereto attached showing the new location of said menu. B)Administrator should check regularly that copies of menus are given to residents and a weekly menu should be hanged and visible for them to see. C) Monitor for Compliance D) Person Responsible: Administrator E) Completion Date: 3/01/2019	03/05/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0277 SS= D	449.2175(8) - Service of Food - Ill Resident - NAC 449.2175 Service of food; seating; menus; special diets; nutritional requirements; dietary consultants. 8. A resident must be served meals in his bedroom for not more than 14 consecutive days if he is temporarily unable to eat in the dining room because of an injury or illness. The facility may serve meals to other residents in their rooms upon request. If a meal is served to a resident in his room because the resident is unable to eat in the dining room, the facility shall maintain a record of the times and reasons for serving meals to the resident in his room. Inspector Comments: Based on observation, record review and interview the facility failed to properly document a resident eating meals in bed for greater than 14 days in a row for 1 of 4 residents (Resident #4). Findings include: Resident #4 (R4) was admitted on 10/19/18 with diagnosis including chronic heart failure and respiratory failure. On 02/25/19 at 11:55 am, R4 was noted being fed by a caregiver while in bed. On 02/25/19 at 1:40 pm, a Caregiver indicated R4 has not been out of bed for a meal since their arrival at the facility. A Caregiver indicated R4 did not want to get out of bed for meals, but staff did not know why. The medical record did not indicate R4 remained in bed for 14 consecutive days. There was no documented record of why R4 remained in bed for meal times. On 02/25/19 at 2:43 pm, the Administrator confirmed there was no recorded log of R4 in bed at meal times for greater than 14 days. Scope: 1 Severity: 2	0277	A) A monitoring log for resident #4 is hereto attached and marked as exhibit "F" TAG Y 0277 evidencing recorded documentation that she has been out of bed mostly during lunch and dinner time. B)Administrator should check monitoring log for resident #4 regularly and always remind caregivers to keep documenting on the said monitoring log. C) Monitor for Compliance. D) Person Responsible: Administrator E) Completion Date: 03/10/2019	03/10/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0357 SS= F	449.222(7) - Bathrooms and Toilet Facilities - NAC 449.222 Bathrooms and toilet facilities; toilet articles. 7. Each resident must have his own toilet articles and must be provided with toilet paper, individual towels and wash cloths. Paper towels may be used for hand towels. The towels and wash cloths must be changed as often as is necessary to maintain cleanliness, but in no event less often than once each week. A soap dispenser may be used instead of individual bars of soap. Inspector Comments: Based on observation and interview the facility failed to provide paper towels or individual hand towels in two restrooms for hand drying for 4 of 4 residents. Findings included: On 02/25/19 at 8:55 am, there was no paper towels and one cloth towel in bathroom number 1. On 02/25/19 at 9:05 am, there was no paper towels and one wash cloth hanging on a towel bar in bathroom number 2. On 02/25/19 at 11:40 am, there was no paper towels in bathroom number 1. On 02/25/19 at 9:10 am, a caregiver indicated paper towels were not left in bathrooms and would be provided to residents after they wash hands and exit bathroom. A caregiver confirmed there were no paper towels in bathrooms number 1 and 2. On 02/25/19 at 2:43 pm, the administrator indicated resident use a common towel in the bathrooms to dry hands. The administrator confirmed paper towels should be in restrooms for hand drying. Scope: 3 Severity: 2	0357	A) Administrator ordered the caregiver to always put paper towels in residents bathroom. Bathroom #1 located in the master bedroom and Bathroom #2 located in the hallway. Hereto attached as exhibit "G" TAG Y 0357 photo of the master bathroom and exhibit "G-1" TAG Y 0357 photo of hallway bathroom. B) A regular inspection of the bathrooms should be done by the Administrator and make sure that paper towels is always available for residents handwashing use. C) Monitor for compliance. D)Person Responsible: Administrator E)Completion Date: 02/26/2019	02/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0527 SS= F	449.260(1)(b) - Activities for Residents - NAC 449.260 Activities for residents. 1. The caregivers employed by a residential facility shall: (b) Provide group activities that provide mental and physical stimulation and develop creative skills and interests. Inspector Comments: Based on observation, interview and document review the facility failed to provide appropriate activities to 4 of 4 residents. Findings include: On 02/25/19 at 8:45 am, Resident #1 (R1) and Resident #3 (R3) were in living room watching TV and Resident #2 (R2) was reading a magazine. Resident #4 (R4) was awake in room and sitting up in bed and there was no TV on. On 02/25/19 at 10:40 am, R1 watched TV in the living room while R3 was asleep and R2 read the same magazine. R4 was still in bed and watched TV. On 02/25/19 at 10:50 am, R1 indicated they were bored and did nothing all. R1 indicated they would like activities but the facility did not offer any. On 02/25/19 at 11:00 am, R4 indicated nothing was offered at the facility to do and they would enjoy something besides sit in bed and watch TV. On 02/25/19 at 12:30 pm, R1, R3 and R4 watched TV in the living room and R4 watched TV in their room. No activities were seen. On 02/25/19 at 1:15 pm, R3 indicated they would like activities such as puzzles and books. On 02/25/19 at 2:25 pm, R2 indicated the facility did not do activities but it would be enjoyable if they did. On 02/25/19 at 2:30 pm, R1 and R3 were in living room watching TV and R2 read same magazine for a third time. R4 was awake in bed and TV was off. No activities were seen. Activity log indicated the activity for 02/25/19 was to watch TV game shows from 6:00 pm to 7:00 pm. The activity log for January indicated to watch TV 22 of 31 days and for 22 of 28 days in February. On 02/25/19 at 2:43 pm, the administrator confirmed the activity calendar for January and February 2019, was to watch TV. Scope: 3 Severity: 2	0527	A) A general meeting with the staff was conducted by the Administrator regarding activities. It's compliance and execution. Exhibit "H" TAG Y 0527 is hereto attached showing the activity schedule. Interviewed residents on there hobbies and preference to do everyday. Came out the resident #2 loves to knit; so we provide her with knitting materials; Puzzles for resident #3; Resident #1 and #4 loves old times movies and music. B) Administrator should see to it that activities are to done mandatory everyday. C) Monitor for Compliance. D) Person Responsible : Administrator E) Completion Date: 02/26/2019	02/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0530 SS= F	449.260(1)(e) - Activities for Residents - NAC 449.260 Activities for residents. (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. Inspector Comments: Based on interview and document review the facilty failed to provide at least 10 hours of activities per week for 4 of 4 residents. Finding include: The activity calendar for December 2018 indicated 9.5 hours of activities were offered the week of 12/09/18 to 12/15/18, 8.5 hours for the week of 12/16/18 to 12/22/18 and 9 hours for the week of 12/23/18 to 12/29/18. The activity calendar for January 2019 indicated 9.5 hours of activities were offered the week of 01/06/19 to 01/12/19, 8.5 hours for the week of 01/13/19 to 01/19/19 and 9 hours for the week of 01/20/19 to 01/26/19. The activity calendar for February 2019 indicated 9.5 hours of activities were offered the week of 02/03/19 to 02/09/19, 8.5 hours for the week of 02/10/19 to 02/16/19 and 9 hours for the week of 02/17/19 to 02/23/19. On 02/25/19 at 2:43 pm, the administrator confirmed 10 hours of activities were not offered weekly. Scope: 3 Severity 2	0530	A) A new activity calendar was revised and indicated therein the hours making sure that we are doing the 10 hours per week requirement as per regulation. Exhibit "I" TAG Y 0530 is hereto attached. B) A weekly checked of the activity calendar should be done by the Administrator. C)Monitor for compliance. D)Person Responsible: Administrator E) Completion Date: 02/28/2019	02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0693 SS= D	449.2712(2) - Oxygen-Caregiver monitor resident ability - NAC 449.2712 Residents requiring the use of oxygen. 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 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. Inspector Comments: Based on observation, interview and record review the facility failed to ensure a full oxygen tank was available for 1 of 4 residents (Resident #4) Findings include: Resident #4 (R4) was admitted on 10/19/18 with diagnosis including chronic heart failure and respiratory failure. A physician's order dated 01/09/19 documented, oxygen (O2), two liters per minute via nasal cannula as needed. On 02/25/19 at 9:05 am, an O2 concentrator was in R4's room. There was no O2 tank seen in R4's room. On 02/25/19 at 9:20 am, an empty O2 tank was found outside in the patio. A caregiver indicated the O2 tank in the patio was empty. On 02/25/19 at 2:43 pm, a caregiver confirmed the only O2 tank in the facility was the empty one outside. Scope: 1 Severity: 2	0693	A) A O2 tank for resident #4 was ordered as evidenced of exhibit "J" TAG Y 0693 photo of the portable tank with the corresponding receipt. B) Administrator should see to it that a portable full O2 tank is available anytime in case of emergencies; especially if there is a resident that need it and have order for it's use. C) Monitor for compliance. D) Person Responsible: Administrator E) Completion Date: 02/26/2019	02/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0920 SS= F	449.2748(1-2) - Medication Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential 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. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview the facility failed to properly store over the counter medications and dispose of a medication for a resident that was discharged. Findings include: On 02/25/19 at 9:00 am, a bottle of Children's Night Time Cold and Cough, Mineral Oil and Tussin CF medicated liquid were located in an unlocked refrigerator in the kitchen. A caregiver confirmed the medications should be locked up and not in the refrigerator. On 02/25/19 at 9:03 am, a bottle Megestrol Acet, 40 mg/ml, for a resident that was discharged in March, 2018, was located in an unlocked refrigerator in the kitchen. A caregiver confirmed the resident had discharged and the medication should not be in the refrigerator and should have been disposed of. On 02/25/19 at 9:40 am, a vial of Mentholatum Vapor rub was located in the den area where residents were watching TV. A caregiver confirmed it should be locked up. Scope: 2 Severity: 3	0920	A) A medication destruction record is hereto attached and marked as exhibit "K" TAG Y 0920 evidencing a bottle of Children's Night time cold and cough; Mineral Oil and Tussin CF; bottle of Megasterol Acet 40 mg/ml are properly disposed. The mentholatum vapor was ordered locked in the medication cabinet. B) Administrator should randomly checked the facility for compliance in the handling of medications. Medications belonging to discharged residents should be disposed right away. And medications that needs refrigeration should be in a locked box inside the refrigerator. C) Monitor for Compliance. D) Person Responsible: Administrator E) Completion Date: 02/25/2019	02/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2176	A. BUILDING _____ B. WING _____	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME CARE, LLC	6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156

(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
0960	449.2754(1) - Alzheimer's Endorsement - NAC 449.2754 Residential facility which provides care to persons with Alzheimer's disease: Application for endorsement; general requirements. 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer ' s disease. The Health Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on record review and interview the facility failed to obtain an Alzheimer endorsement for 2 of 4 residents (Resident #1 and Resident #2). Findings include: Resident #1 (R1) was admitted on 05/07/18 with diagnosis including dementia and insomnia. Resident #2 (R2) was admitted on 08/16/13 with diagnosis including dementia and hypertension. Health and Physical dated 05/01/18 documented R1 was diagnosed with dementia. Health and Physical dated 08/13/13 documented R2 was diagnosed with dementia. State of Nevada license dated 01/01/19 inidicted the facility was not licensed for Alzheimer residents. On 02/25/19 at 10:50 am, a mini cognitive assessment indicated R1 was alert and oriented to time of day only. On 02/25/19 at 1:15 pm, a mini cognitive assessment indicated R2 was alert and oriented to time of day only. On 02/25/19 at 1:40 pm, the administrator confirmed the facility was not endorsed for Alzheimer residents. The administrator confirmed R1 and R2 had a diagnosis of dementia.	0960	A) A written statement for Resident #1 by her physician indicating that she doesn't have behavioral disturbance. That she will benefit living in this group home because she can still function/perform ADL's with minimal assistance. Hereto attached is exhibit "L" TAG Y 0960 said letter from her physician. A written letter from Resident #1 daughter indicating that her mom is contented where she is right now. And that she doesn't want to move her to a different facility as she is already used to her surroundings and happy with the care that she is getting. Exhibit "L-1" TAG Y 0960 is hereto attached. A written statement for Resident #2 by her physician indicating that she knows her medical history and functional limitations and that she doesn't need to be living in an Alzheimer related Dementia facility. Exhibit "M" TAG Y 0960 is hereto attached evidencing said letter. B) Administrator should do every 3 months cognitive assessment to Resident #1 and #2 and every 6 months cognitive assessment from their physician to monitor any changes in behavioral condiction. C) Monitor for compliance. D) Person Responsible : Administrator E) Completion Date: 03/07/2019	03/07/2019