

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2021
NAME OF PROVIDER OR SUPPLIER SAINT JUDE HOME CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6880 HATHAWAY DRIVE, LAS VEGAS, NEVADA ,89156		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure and infection control survey conducted at your facility on 08/17/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of survey was four. Four resident files and five employee files were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiency was identified:			

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 Name: MARIA T. N. ACOBA Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 08/20/2021

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(X4) ID PREFIX TAG 0050 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0050	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 08/20/2021
	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) 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 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation and interview, the facility failed to conduct a COVID-19 screening and temperature check for visitors upon entry into the facility. A Caregiver confirmed they were not currently screening non residents who entered the facility. Severity: 2 Scope: 3		1) After the survey done on August 18, 2021; Administrator issued a memorandum and is hereby attached and marked as exhibit "A". Said memorandum is posted by the front door. Re-trained employees on COVID-19 screening and temperature checking. 2) Administrator should checked the facility regularly and see to it that employees are following said memorandum. 3) Monitor for compliance. 4) Person responsible: Administrator Completion date: August 20, 2021 5)	