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 _____	**09/11/2024**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated in your facility on 08/06/24 and completed on 09/11/24, 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 five. Five resident files and four employee files were reviewed. The facility received a grade of B. There was one complaint investigated. Substantiated: 1. Complaint # NV00071607 was substantiated (see Tags Y860 and Y0174). The investigation of the complaint included: Observations of grooming and physical appearance of residents, odors in the facility, cleanliness of the facility, interactions between staff and residents, and temperatures within the facility. Interviews were conducted with residents, caregiver staff, the Owner's representative, and resident family members. Clinical Record Review of five records, which included the resident of concern. Document review included hospice care notes. 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 deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JESSICA COBB Title: Administrator Date: 10/07/2024

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.

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0174 SS= D	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the room was free of urine and body odor for 1 of 5 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 06/15/24 with a diagnosis of orthopedic aftercare following surgical amputation. On 08/06/24 at 12:20 PM, R1 was observed lying in bed on multiple wet incontinence pads (chux pads). The room smelled of urine and body odor. The odors seemed to travel through the vents and the odors could be detected in the kitchen. On 08/06/24 at 12:25 PM, the Caregiver explained R1 used the urinal and had the behavior of pouring urine from the urinal onto the bed. On 08/06/24 in the afternoon, the Owner's representative reiterated that R1 did pour urine onto the bed after using the urinal. The Owner's representative acknowledged the room was odiferous and attributed the body odor smell to R1's wound. Severity: 2 Scope: 1	0174	1. Resident and resident's bed was changed and cleaned up. The urinal and trash was emptied and the room was aired out. 2. Resident was put on 2 hour checks to ensure the resident, bed and bedding are clean and dry. 3. Group Home manager will check with resident and log daily. 4. The Group Home manager will be responsible. 5. This plan of correction was implemented on 8/7/2024.	08/07/2024

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0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure 1 of 5 resident rooms had a screen on their bedroom window to keep out insects (Resident #1). Findings include: On 08/06/24 at 12:20 PM, Resident #1's bedroom window was open and without a screen. On 08/06/24 at 1:30 PM, the Caregiver explained the window was open because R1 reported they were cold. The Caregiver explained they opened the window every morning and closed it at night. On 08/06/24 in the afternoon, the Owner's representative acknowledged the lack of a screen on the open window which allowed for the entry of insects into the house. Severity: 2 Scope: 1	0179	1. An Air conditioner unit was added to the window to help circulate cool air. 2. The outside of the house will be monitored monthly to ensure all windows have appropriate screens in place. 3. The Group Home manager will be responsible. 4. The house will be inspected monthly to ensure screens are properly placed. 5. The air conditioner was place 8/7/2024	08/07/2024
0181 SS= F	Health & Sanitation-Temperature - NAC 449.209 Health and sanitation. (NRS 449.0302) 8. The temperature in the facility must be maintained at a level that is not less than 68 degrees Fahrenheit and not more than 82 degrees Fahrenheit. Inspector Comments: Based on observation and interview, the facility failed to maintain temperatures below 82 degrees Fahrenheit throughout the home. Findings include: on 08/06/24 at 1:20 PM, the thermostat in the hall read 83 degrees Fahrenheit. On 08/06/24 in the afternoon, the temperature in the kitchen was 88.3 degrees Fahrenheit, the temperature in the community room was 87.6 degrees Fahrenheit, the temperature in the entry way was 87.4 degrees Fahrenheit, the temperature in the front room was 87.4 degrees Fahrenheit, and temperatures in resident rooms were 86.1, 85.2, and 85.8 degrees Fahrenheit. On	0181	1. An air conditioner repair company was called on 8/6/2024. 2. The air conditioner was serviced/repaired on 8/7/2024. 3. Room/house temperature will be monitored daily to ensure that the air conditioner is operating correctly. 4. The group home manager will be responsible for ensuring proper temperature in the house. 5. 8/7/2024	08/07/2024

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	08/06/24 at 2:20 PM, Resident #4 (R4) verbalized the temperature in the community room was warm and the temperature in the home stayed warm throughout the day. R4 verbalized they were not really comfortable due to the warm temperature. They shared sometimes the temperature would go down, but not very often. On 08/06/24 at 2:22 PM, family members of Resident #2 (R2) shared they thought R2's room was warm. On 08/06/24 in the afternoon, the Owner's representative acknowledged the temperatures were elevated, and explained the Owner was aware of the problem and was looking for someone to fix the air conditioning, but had no time frame to do so. The Owner's representative reported they knew some vents were not working, and the home got a little hot. On 08/06/24 in the afternoon, the Owner confirmed the temperatures taken throughout the facility and acknowledged the Air conditioning was not working properly. The Owner provided more fans and a portable air conditioning unit to cool the house down until the air conditioner was able to keep the facility at a temperature below 82 degrees Fahrenheit. On 08/07/24 in the morning, the Owner explained a representative from a local air conditioning company put in a new thermostat. The old thermostat was not efficient enough to keep the temperatures below 82 degrees Fahrenheit. Severity: 2 Scope: 3			

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0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on interview and record review, the facility failed to develop a person-centered service plan for 1 of 5 residents (Resident #1). Resident #1 (R1) R1 was admitted on 06/15/24 with a diagnosis of orthopedic aftercare following surgical amputation. On 08/06/24 in the afternoon, R1 had a urinal by bedside and the room smelled of urine. On 09/11/24 in the afternoon, the Owner's representative verbalized the facility asked R1 to notify them when R1 had urinated into the urinal, so the facility could empty it. The Owner's representative explained R1 did not do this often, however if the facility did not empty the urinal R1 would urinate in the urinal again causing the urine to be poured on the bed. A review of facility Caregiver Report Sheets for July 2024 and August of 2024 revealed R1 often refused to be changed or have the bed sheets changed. R1's file lacked documented evidence of a person-centered service plan to address R1's issue with the accidental pouring of urine from R1's urinal onto R1's bed and R1's refusal to be changed or the bed sheets changed. Therefore the chux on R1's bed were frequently wet. Severity: 2 Scope: 1	0515	1. A person centered care-plan will be created with every new admission. It will be update semi-annually and with any significant change. 2. The group home manager will ensure a person centered care plan is created for every resident and is updated as needed to ensure the needs of the resident are met. 3. A chart audit will be completed quarterly to ensure that each resident's care plan meet their current needs, to include any interventions needed or used. 4. The Group Home manager will be responsible.	08/09/2024
0860 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical	0860	1. A person centered care-plan will be created with every new admission. It will be update semi-annually and with any significant change.	08/09/2024

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	care by resident; written records. (NRS 449.0302) 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he or she requires. (b) Monitor the ability of the resident to care for his or her own health conditions and document in writing any significant change in his or her ability to care for those conditions. Inspector Comments: Based on observation and interview, the facility failed to ensure 1 of 5 residents was kept dry of urine and odor free (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 06/15/24 with a diagnosis of orthopedic aftercare following surgical amputation. On 08/06/24 at 12:20 PM, R1 was observed lying in bed on multiple wet incontinence pads (chux pads.) R1's adult diaper did not appear wet and the room smelled of urine and body odor. R1 verbalized the Caregiver had changed the adult brief twice that day, and sometimes they changed it three or more times. On 08/06/24 at 12:21 PM, the Caregiver verbalized they changed the adult brief when they saw it was wet and reported to changing the brief twice that day and explained they changed it daily when needed. The Caregiver explained R1 used the urinal and had the behavior of pouring urine from the urinal onto the bed. On 08/06/24 in the afternoon, the Owner's representative reiterated that R1 poured urine from their urinal onto the bed. R1's urinal was observed to be empty. The Owner's representative verbalized the Caregivers kept a log of when they changed R1, but the log could not be located. R1's file lacked documented evidence of how the facility would address R1's behavior of pouring urine from the urinal onto the bed. On 08/06/24 in the afternoon, the Caregiver acknowledged the chux pads on R1's bed were wet and proceeded to change R1. The Owner's representative acknowledged the room was odiferous and attributed the smell to R1's wound. R1 received regular wound		2. The group home manager will ensure a person centered care plan is created for every resident and is updated as needed to ensure the needs of the resident are met. 3. A chart audit will be completed quarterly to ensure that each resident's care plan meet their current needs, to include any interventions needed or used, as well as anytime the resident refuses care. 4. The Group Home manager will be responsible.	

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	care from the hospice company. Severity: 2 Scope: 1			