Division of Public and Behavioral Health

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 _____	06/25/2025

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 an annual State Licensure survey completed at your facility on 06/25/25 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 the survey was three. Three resident files and four employee files were reviewed. The facility received a grade of B. 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 regulatory deficiencies were identified:	0000		

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: JESSICA COBB | Title: Executive Director | Date: 08/18/2025

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interviewe, record review and document, the facility failed to ensure 1 of 4 employees met the background check requirements of Nevada Administrative Code (NAC) 449.0113 (Employee #1). Findings include: Employee #1 (E1) E1 was hired on 04/01/24 as the Administrator. E1's file lacked documented evidence of a Nevada Automated Background Check System (NABS) Clearance Letter for the facility being surveyed. An inquiry into the NABS database revealed E1 had background clearance letters for three other facilities dated 12/29/20, 08/28/21, and 08/05/21. E1 did not have a NABS background clearance for the facility being surveyed. On 06/25/25 in the afternoon, the Owner was unaware a background check was not conducted upon hire for the Administrator. Severity: 2 Scope: 1	0104	Employee 1 had fingerprints done before receiving access to NABs for St. Jude. 1. Employee 1 was entered into NABs and clearance letter was placed in file. 2.Group Home manager will audit all employee files to ensure clearance letter is in place. 3.The administrator will audit all new employee files after hire to ensure all new hire information is in the file, and other employees files quartly. 4. The group home manager and administrator will monitor for compliance.	08/07/2025

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0430 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation and interview, the facility failed to ensure the fire extinguishers were inspected annually. Findings include: Four fire extinguishers were observed in the facility. The inspection tags on two of the fire extinguishers were dated 11/10/23, and the inspection tags on the other two fire extinguishers were dated 05/04/24. On 06/25/25 in the morning, the Owner acknowledged the inspection tags on the four fire extinguishers indicated overdue inspections,but felt certain the checks had been completed. However, the Owner was unable to provide evidence which supported that the fire extinguishers had been inspected annually. Severity: 2 Scope: 3	0430	1. Fire Extinguishers were inspected. 2. Contract with Dessert Fire to ensure fire extinguishers are inspected annually. 3. Group Home manager to ensure fire extinguishers are being inspected and are working properly. 4. Group Home Manager and Administrator	08/11/2025
0856 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 care by resident; written records. (NRS 449.0302) 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. Inspector Comments: Based on observation, interview and record review, the Administrator failed to ensure a resident received medical care from a physician after a resident was discharged from hospice	0856	1. Resident was admitted to a new Hospice service. 2. Policy was created to ensure that all residents discharged from Hospice service have a PCP when discharged from Hospice services. 3. Group Home manager will ensure the policy is followed.	06/30/2025

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	care (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 11/19/18 with diagnoses including cerebrovascular accident and atrial fibrillation. R1 was discharged off hospice in May 2025. On 06/25/25 R1's medication bin contained Ciprofloxacin Ophthalmic Solution 0.3%, the medication packaging documented a prescription date of 05/20/25, with the instructions to instill 2 drops on affected eye every four hours for seven days. R1's June 2025 Medication Administration Record (MAR) documented Ciprofloxacin Ophthalmic Solution 0.3%, instill two drops on affected eye every four hours for seven days. Documentation on the June MAR indicated Ciprofloxacin was administered at 7:00 AM and 7:00 PM for seven days from June 1 through June 7, for another seven days from June 10 through June 16, and for another seven days from June 19 through June 25. On 06/25/25 at 3:00 PM, Employee #3 (E3) explained the hospice company had given the facility a verbal order to give R1's eye infection a break from the medication after seven days, and if the infection hadn't resolved, to administer the medication for another seven days. There were no physician orders on site, as R1 had already been discharged from the hospice company in May, and R1's family member was working with the insurance company to procure another physician for R1. E3 had called the hospice company in May to tell them that R1's eye had an abundance of mucous. The representative from the hospice company office told E3 that they were just being considerate and placed an order for the antibiotic for R1 because R1 had already been discharged from hospice. A physician's order was not acquired. R1's file lacked documented evidence of an assessment of R1's eye infection by a physician prior to administering more eye drops for the months of May and June 2025 after being discharged from hospice care. On 063/25/25 in the afternoon, E3 confirmed R1 was not currently under the care of a physician, and there were no current physician orders because R1 had been discharged from hospice care. Severity: 2 Scope: 1			

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 3 residents had Ultimate User Agreements in their files (Residents #1 and #3), and 2 of 3 residents did not have range orders for their medications (Residents #2 and #3). Findings include: Resident #1 (R1) R1 was admitted on 11/19/18 with diagnoses including cerebrovascular accident and atrial fibrillation. R1's file lacked documented evidence of an Ultimate User Agreement. Resident #3 (R3) R3 was admitted on 02/26/24 with diagnoses including congestive heart failure exacerbation and chronic kidney disease. R3's file lacked documented evidence of an Ultimate User Agreement. On 06/25/25 in the afternoon, the Owner acknowledged R1 and R3 should have had signed Ultimate User Agreements in their files. Resident #2 (R2) R2 was admitted on 05/03/25 with diagnoses including pneumonia and anemia. R2's June 2025 Medication Administration Record contained the following orders: - Furosemide 40 milligram (mg) Lasik, take one tablet by mouth, start when blood pressure (BP) is greater than 110 Systolic Blood Pressure (SBP) and heart rate (HR) is greater than 60. - Potassium Chloride Extended Release 20 milliequivalents (meq) tablet, KLOR-CON, take one tablet, start when BP is greater than 110 SBP and HR is greater than 60. - Metoprolol Tartrate 100 mg tablet, take one tablet, restart when BP is greater than 110	0876	1. Med tech's were trained on parameter medication orders on June 28th, 2025. 2. Group Home manager to review all new orders to ensure proper orders are received and provider is followed up with if needed. 3. Medication audits to be performed by Group Home Manager to ensure proper orders. 4. Group Home Manager	06/28/2025

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	SBP and heart rate is greater than 60. - Amlodipine 10 mg Norvasc, take one tablet by mouth, start when BP is greater than 110 SBP and heart rate is greater than 60. A Nurse Practitioner's order dated 05/14/25 documented, Pause amlodipine, metoprolol, furosemide and potassium. Can restart when BP was greater than 110 SBP and heart rate is greater than 60. Please check BP every morning prior to medication administration. An Advanced Practice Registered Nurse's order dated 05/21/25 documented, Restart amlodipine, metoprolol, furosemide, and Potassium. Keep parameters and hold Metoprolol and amlodipine for BP-Systolic less than 110 and heart rate less than 60. R2's medication bin contained medications labeled: - Furosemide 40 mg tablet, generic for Lasik, take one tablet by mouth once daily. The facility added a sticker to the bottle which documented: See physician summary for changes. - Potassium Chloride Crys Extended Release 20 meq tablet, generic for KLOR-CON, take one tablet by mouth once daily. The facility added a sticker to the bottle which documented: See physician summary for changes. - Metoprolol Tar 100 mg tablet,generic for Lopressor, take one tablet by mouth once daily. The facility added a sticker to the bottle which documented: See physician summary for changes. - Amlodipine 10 mg tablet, generic for Norvasc, take one tablet by mouth once daily. The facility added a sticker to the bottle which documented: See physician summary for changes. On 06/25/25 in the morning, Employee #3 (E3) explained they took and recorded R2's blood pressure daily, and notified R2's healthcare provider's office if the blood pressure was out of the expected range. E3 indicated R2's healthcare provider did not want to change R2's medication orders for Furosemide, potassium chloride, Metoprolol and amlodipine to reflect a maintenance level of the medications, but wanted E3 to take R2's blood pressure in order to make a determination of whether to administer or hold the medication. Resident #3 (R3) R3's June 2025 MAR documented Hydralazine 25 mg tablet, take one tablet by mouth twice a day as needed if systolic blood			

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	pressure above 160. A healthcare provider order dated 03/18/25 documented, Patient had been noted to have low blood pressure per caregiver report. Discontinue chlorthialidone 25 mg. Change order: Hydralazine 25 mg, one tablet by mouth twice a day as needed for systolic blood pressure 160 and above. R3's medication bin contained Hydralazine 25 mg tablet, take one tablet by mouth twice a day as needed for systolic blood pressure 160 and above. On 06/25/25 in the afternoon, the Owner acknowledged R2 and R3 should not be prescribed range orders for the administration of medications and verbalized the facility had discussed their concerns with the healthcare providers. Severity: 2 Scope: 2			
1825 SS= E	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated	1825	1. Employee 3 and employee 4 will complete the approved 15 hour training through the CDC website before September 18, 2025. 2. Training log will be created and up kept to ensure all associates have the required training. 3. Training log will be audited quarterly to ensure proper training has been completed timely. 4. The group Home Manager will be responsible to ensure all trainings are completed.	09/18/2025

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	pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control staff completed 15 hours of annual and initial infection control training (Employees #3 and #4). Employee #3 (E3): E3 was hired as the Owner/Caregiver/Director on 04/01/24. On 06/25/25 in the afternoon, E3 was identified as the current primary infection control person for the facility. E3's file contained documentation of approved infection control training completed on 06/08/24. E3's infection control training expired on 06/08/25. E3's file lacked documented evidence of annual 15 hours of infection control training regarding the control and prevention of infections from an approved organization in 2025. Employee #4 (E4): E4 was hired as a Caregiver on 04/01/24. On 06/25/25 in the afternoon, E4 was identified as the current secondary infection control person for the facility. E4's file lacked documented evidence of a total of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. On 06/25/25 in the afternoon, E3 acknowledged E3 had not completed 15 hours of annual approved infection control training, and E4 had not completed a total of 15 hours of initial approved infection control training. Severity: 2 Scope: 2			

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1840 SS= D	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 Caregivers completed the annual required infection control training for unlicensed caregivers (Employee #1). Findings include: Employee #1 (E1) E1 was hired as the Administrator on 04/01/24. E1's file contained documentation of 15 hours of approved infection control training, completed on 09/08/23. E1's file lacked documented evidence of the required infection control training for unlicensed caregivers provided by a nationally recognized organization, completed in 2025. On 06/25/25 in the afternoon, the Owner confirmed E1 did not complete the required annual infection control and prevention training. Severity: 2 Scope: 1	1840	1. Employee 1 completed her infection control training. 2. Training log will be created and up kept to ensure all associates have the required training 15 hours originally and 4 hours hours annually. 3. Training log will be audited quarterly to ensure proper training has been completed timely. 4. The group Home Manager will be responsible to ensure all trainings are completed.	08/12/2025