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
	2839	A. BUILDING _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT FRANCIS GROUP HOME CARE V	4245 E BALTIMORE AVE, LAS VEGAS, NEVADA ,89104

(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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey initiated at your facility on 01/08/26. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category I residents. The census at the time of the survey was five. Five resident files and four employee files were reviewed. The facility received a grade of A.			
Y 0930 SS= E	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the	Y 0930	Tag Y0930 A) Resident #2 ,Resident #4 and Resident #5 Activities of Daily Living has been completed and signed by the Administrator on 1/8/26 . B) The Administrator will make sure that the Resident files will be reviewed in a timely manner so that all the important aspects in their file are updated and to prevent it from happening in the future .The Administrator will monitor for compliance. C) Date of Completion :1/8/26 D) Attachments : Activities of Daily Living	01/08/2026

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	resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of			

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	protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility.			

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	2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on interview and record review the facility failed to ensure annual Activities of Daily Livings (ADL) assessments were completed for 3 of 5 sampled residents (Resident #2, Resident #4, and Resident #5). Findings include: Resident #2 (R2) R2 was admitted to the facility on 01/01/22 with a diagnosis of schizophrenia. R2 had an initial ADL assessment completed on 01/01/22, but the record lacked			

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	documented evidence an annual ADL assessment had been completed since. Resident #4 (R4) R4 was admitted to the facility on 06/06/23 with a diagnosis of schizophrenia. R4 had an initial ADL assessment completed on 06/06/23, but the record lacked documented evidence an annual ADL assessment had been completed since. Resident #5 (R5) R5 was admitted to the facility on 09/20/22 with a diagnosis of schizophrenia. R5 had an initial ADL assessment completed on 09/18/24, but the record lacked documented evidence an annual ADL assessment has been completed since. On 01/08/26 in the morning, the Administrator verified that annual ADL assessments had not been completed for R2, R4, and R5. Severity: 2 Scope: 2			