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 _____	**04/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN VICENTE HOME CARE	**8460 RANCHO DESTINO RD, LAS VEGAS, NEVADA ,89123**

(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 complaint investigation completed in your facility on 04/22/2024, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The census at the time of the survey was ten. The sample size was five. The facility received a grade of A. There were two complaints investigated. Substantiated without deficient Practice: 1. Complaint #NV00070683 was substantiated with no deficient practice. Substantiated: 2. Complaint #NV00070804 was substantiated with no deficient practice. The investigation of Complaints included: Observation of grooming and physical appearance for residents, no residents wondering or exit seeking and a tour of the facility. Interviews were conducted with Caregivers, and the Administrator. Record Review of five records, which included the residents of concern. 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. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: VISITACION T. DELA PENA | Title: Administrator | Date: 06/17/2024

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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0853 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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on interview and record review, the facility failed to ensure an incident report was completed for a resident who had eloped from the facility for 1 of 5 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 11/17/19 with a diagnosis of neoplasm of the brain. On 04/22/2024 at 8:53 AM, the Administrator indicated R2 had eloped from the facility on 02/22/2024, and was located by police and returned to the facility. R2's file lacked documented evidence of an incident report for the elopement. On 06/05/2024 in the afternoon, the Administrator acknowledged an Incident Report had not been completed. The Administrator indicated an incident report should have been completed for the elopement. Severity: 2 Scope: 1	0853	Tag 0853 06/17/2024 1. Created a Policy and Procedure for Elopement. 2. Training of staff regarding identified residents with risk of elopement. 3. a: Assigned a staff responsible for headcount every hour and as necessary assigning team leader and administrator as responsible people to do the headcount. b: Put additional safety door locks and ringing devices to ensure the alert of doors opening. 4. Staff Team Leader and Administrator will ensure that the plan of correction is implemented. 5. Completed June 16, 2024 6. Uploaded the Policy and Regulation for Elopement at the POC site. 7. Continuous assessment of residents manifesting risk for elopement.	06/17/2024