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 _____	**06/16/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE RESIDENTIAL CARE CORP	**3158 KINGSPOINT AVENUE, LAS VEGAS, NEVADA ,89120**

(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 survey initiated at your facility on 06/13/20 and finalized on 06/16/20. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was zero. The facility was closed The sample size was seven. One complaint was investigated. Complaint # 61152 with two allegations was unsubstantiated. Allegation #1 - The facility failed to inform residents and family members about COVID-19 in the facility was unsubstantiated based on discharge information documenting all residents were discharged from the facility immediately after it had received notification of a positive case of COVID-19 Allegation #2 - The facility failed to maintain adequate infection control measures was unsubstantiated based on the facility had personal protective equipment (PPE) a thermometer, hand sanitizer and disinfectant products available. The facility was following CDC and State of Nevada guidelines limiting visitors, conducting temperature checks on residents and essential healthcare workers. The facility also had signs posted that limited visitors to essential healthcare workers. The investigation into the allegations included: Interviews were conducted with the facility manager and the complainant. Record reviews of admission and discharge documents of seven residents and COVID-19 testing results for two employees, and State of Nevada and Center's of Disease Control guidelines/recommendations. Observations of the facility environment and supply of PPE, hand sanitizer, temporal thermometer, and disinfectants.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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.