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
	5936	A. BUILDING _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JEAN SENIOR CARE	6924 ACOMA CRT, LAS VEGAS, NEVADA ,89145

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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 05/21/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II 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 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: PRESCILA BARCELON	Title: Administrator	Date: 06/25/2025

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0515 SS= F	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 5 of 5 residents (Residents #1, #2, #3, #4, and #5). Findings include: Resident #1 (R1) R1 was admitted on 01/01/24 with a diagnosis of senile degradation of the brain. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted on 05/02/24 with diagnoses including debility, impaired gait, and impaired ADLs (Activities of Daily Living). R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted on 08/12/23 with acute psychosis and chronic bipolar disorder. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted on 08/04/23 with diagnoses including hypertension and Type 2 Diabetes Mellitus. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted on 03/08/21 with diagnoses including dementia, severe muscle atrophy, and schizophrenia. R5's file lacked a person-centered service plan. On 05/21/25 at 11:28 AM, the Administrator acknowledged person-centered service plans were not developed for R1, R2, R3, R4, and R5. Severity: 2 Scope: 3	0515	Tag#0515 - On 05/23/2025, our Administrator developed a Person-Centered Service Plan form, to which we filled up for every single resident and filed them into every individual resident's file. Attached here is a copy of every Residents Service Plan for your review. E2, Caregiver/House Manager will be in charge to review all residents file quarterly for compliance. Our Administrator will check all residents file twice a year for compliance.	06/23/2025

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 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) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 residents received an annual physical examination (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 08/24/23 with diagnoses including hypertension and Type 2 Diabetes. A review of R4's file revealed R4's most recent physical examination was performed on 03/22/24. R4's file lacked documentation of an annual physical examination in 2025. On 05/21/25 at 11:20 AM, the Administrator confirmed R4 lacked a current physical examination. The Administrator explained R4's public guardian reported a lack of of funds to complete the examination. Severity: 2 Scope: 1	0859	On 05/27/2025, Our R4 was visited by her Nurse Practitioner, and she had a Physical Exam and had her History and Physical done. Attached here is a copy of her History & Physical for your review. E2, Caregiver/House Manager will review all Residents file quarterly for compliance.	06/23/2025
1010 SS= D	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915.	1010	Our Administrator had been in contact with the Clark County Guardian to relocate R3 in a more suitable home for her. At this time we were informed by the Clark County Guardian that they are looking for a place capable of caring for R3. Our Administrator will review the History & Physical of all prospective residents before admission for compliance.	06/23/2025

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	Inspector Comments: Based on record review and interview, the facility failed to obtain an endorsement for Mental Illness (MI) and retained 1 of 5 residents with an MI diagnosis (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 08/12/23 with diagnoses including acute psychosis, chronic bipolar disorder and disorganized schizophrenia. R3's file included the report from a domiciliary visit dated 02/25/25 which documented: -Patient (R3) was seen for a problem focused follow up. Caregivers reported R3 threw a vase a few days ago when told they cannot eat at that time and had to turn their TV volume down. Provider discussed redirection techniques and the Administrator cited safety concerns. -R3 was prescribed Seroquel 100 milligram (mg) tablet, DISCONTINUE THIS MEDICATION on 02/26/25. -R3 was prescribed Risperidone 1 mg/milliliter (ml) oral solution, take two milliliters by oral route two times every day on 02/26/25. -R3's record documented an Assessment/Plan dated 02/25/25 by the Advanced Practice Registered Nurse (APRN). 1. Assessment dated 02/25/25: R3 had Mild dementia with other behavioral disturbance, unspecified dementia type. The Patient Plan was R3 had a public guardian, lived in a group home and R3 received the appropriate level of care. 2. Assessment dated 02/25/25: R3 had disorganized schizophrenia. The Patient Plan was R3 had Delusional thoughts. R3 consistently refused medications, was agitated and had an episode where R3 threw a vase after being told no food and the TV volume was turned down, the facility called 911. The APRN discussed POC (plan of care) with administrator and Clark Count Public Guardian (CCPG). On 05/21/25 in the afternoon, the Administrator acknowledged R3 had schizophrenia and had been retained in the group home since last year without the facility obtaining a Mental Illness endorsement, due to maintaining communication with R3's guardian and R3's healthcare provider, R3's improved behaviors, and R3's more current dementia diagnosis. This was a repeat deficiency from the 04/08/24 annual survey. Severity: 2 Scope: 1			

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1600 SS= D	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility failed to ensure there were policies developed and	1600	E3 and E4 revised our admission form adding preferred name/pronoun through the admission questionnaire. Attached here are the copies of revised admission form. A copy of our Policies and Procedures concerning Preferred names and Pronouns is attached here for your review. E3 IT officer #2/caregiver, E4 IT Officer #1/ Administrator/caregiver will monitor all files quarterly for compliance.	06/23/2025

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	resident records revised in compliance with R016-20 Section 19, regarding resident records to reflect resident preferred name and pronoun, gender identity or expression and sexual orientation. Findings include: On 05/21/25 in the morning, the six resident records, Residents #1, #2, #3, #4, and #5, lacked documentation to be in compliance with R016-20 Section 19. On 05/21/25 at 11:28 AM, the Administrator confirmed there were no policies regarding preferred pronouns, gender identity or expression and sexual orientation, and the resident records did not reflect this information. Severity: 1 Scope: 3			