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 _____	**03/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT MICHAEL GROUP HOME	**3980 PLACITA AVENUE, LAS VEGAS, NEVADA ,89121**

(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 initiated at your facility on 03/03/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was five. The sample size was five. There was one complaint investigated. Complaint #NV00060208 with one allegation was substantiated. Allegation #1: A resident did not complete lab work, which resulted in a necessary medication not being received, in accordance with the physician's orders. (See Tag 860). 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. The following regulatory deficiency was identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: PETER DURIAS Title: ADMINISTRATOR Date: 03/17/2020

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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0860 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) 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he or she requires. (b) Monitor the ability of the resident to care for his or her own health conditions and document in writing any significant change in his or her ability to care for those conditions. Inspector Comments: Based on interview and record review, the facility failed to ensure lab work was done weekly for 1 of 5 residents (Resident #1). Resident #1 required a complete blood count (CBC) be drawn weekly in accordance with physician's standing orders. There was a CBC drawn on 01/16/20 and the next one was completed on 01/30/20. The owner acknowledged there was a one week gap between CBCs being drawn. Severity: 2 Scope: 1 This was a repeated deficiency cited at the 01/22/20 complaint investigation survey. Complaint #NV00060208	0860	0860 a) After survey administrator checked on the frequency of blood testing on said resident. Record shows that there was a change from weekly to a 2-week interval. b) Administrator shall include blood testing scheduling during the next employee's meeting. c) Administrator shall monitor resident file on this matter during his regular monthly walk through. d) Person responsible: Administrator f) Date of compliance: March 17,2020	03/17/2020