

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2022
NAME OF PROVIDER OR SUPPLIER CASA NORTE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4935 NORTH MILLER LN, LAS VEGAS, NEVADA ,89149		
(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 02/03/22 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, with endorsements for chronic illness, mental illness and individuals with intellectual disabilities, four Category I and five Category II residents. The census at the time of the survey was nine. The sample size was four. One complaint was investigated. The facility received a grade of A. Complaint # NV00065321 with two allegations was unsubstantiated. Allegation #1-The allegation a staff member of the facility drove recklessly with residents on board was unsubstantiated based on interviews with the facility Services Supervisor, Behavior Technician/Driver, two Behavior Technicians and four facility residents which revealed no issues with the driving habits of the facility Driver as well as documentation the facility's Driver had proper training and certification. There was no evidence of facility safety violations. Allegation #2-The allegation residents were screaming for help in the facility's backyard was unsubstantiated based on interviews with the facility Services Supervisor, Behavior Technician/Driver, two Behavior Technicians and four facility residents which revealed no issues with quality of care at the facility. The facility employees and residents were aware of one resident who would occasionally go out to the backyard and talk to himself very loudly, however there was no observations or documented evidence of residents screaming for help. The investigation into the allegations included: Interviews with the facility Services Supervisor, Behavioral Technician/Facility Driver, two Behavior	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.

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	Technicians and four residents. Review of facility driver training and certification and facility safety documentation. 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 is necessary. Please retain a copy for your records.				