STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11029	A. BUILDING _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. FRANCIS GROUP HOME # 2	4151 E. SAINT LOUIS AVENUE, LAS VEGAS, NEVADA ,89104

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed in your facility on 09/29/26. The facility is licensed for 9 Residential Facility for Group beds for elderly and disabled persons and/or individuals with mental illness, Category I residents. The census at the time of survey was Nine. Nine resident files and three employee files were reviewed. The facility received a grade of A.			
Y 0878 SS= D	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced	Y 0878	1) Moving forward, the facility will have the Administrator give extra training to the Caregiver on how to correctly maintain the accuracy and integrity of each resident's MAR. As observed in the SOD, R1's MAR did not accurately depict the progression of the Ondansetron being finished and then having no refills on the RX. The RX had been discarded by the Caregiver after the medication was gone. Furthermore, clarification should have been obtained by the Caregiver on the exact dosage needed as the physician's order was ambiguous on whether 1 or 2 tablets should be given of the medication itself, so the Administrator will re-train the Caregiver to contact physicians to get more exact parameters. The Administrator will re-train the Caregiver on updating the MAR when medications have run their course with no refills. 2) To ensure that the deficient practice does not recur, Administrator and Owner will continue to conduct weekly checks on the MAR and medications as has been the practice but also adding the additional act of confirming verbally with the Caregiver on	10/13/2026

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	practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interviews, and record review the facility failed to ensure medications were on site and available for 1 of 9 sampled residents. (Resident #1) Findings include: R1 was admitted on 12/03/25 with diagnoses including schizophrenia.		whether any changes may have happened to ensure that everything written down is accurate. 3) Both Administrator and Owner will be communicating weekly on whether they have observed any issues with the MAR for the week and confirming that they have both spoken with Caregiver to ensure accuracy of the MAR as well. Furthermore, a new weekly MAR Review Log will be implemented that can be signed by Administrator/Owner and Caregiver to denote who has reviewed the MAR so far. The Log will have checkboxes for ease of review and kept for internal records and reference as needed. 4) Administrator and Owner will both be responsible for ensuring the plan of correction is implemented. 5) The corrective action has already been enacted as of 10/13/26, with the Caregiver having received her review of correct MAR maintenance and both Administrator and Owner having started the practice of communicating with each other on how their weekly MAR reviews go to confirm accuracy along with the newly added verbal checks with Caregiver. The new MAR Review Log has also been implemented at the facility. 6) For reference, facility is including the missing RX from the visit with R1 name and DOB redacted. The RX will show that there was no refill required for the medication and per the Caregiver, 1 tablet was given as needed until medication was out. A copy of the new Weekly MAR Review Log will be included as well.	

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	R1's record contained a physician's order dated 09/08/26 for ondansetron 4 milligram tablet, take 1 - 2 tablets every 8 hours as needed for nausea and vomiting. R1's MAR dated September of 2026 documented R1's ondansetron 4 milligram tablet, take 1 - 2 tablets every 8 hours as needed for nausea and vomiting. Ondansetron was not on site and available to be administered if R1 requested it. On 09/29/26 in the morning, a Caregiver verbalized R1 had been prescribed the ondansetron during an emergency room visit and was administered it for three days and needed it no longer, and the ondansetron was discarded. On 09/29/26 in the morning, the Administrator acknowledged R1's file lacked evidence the ondansetron was discontinued, was not documented as discontinued on R1 September 2026 MAR, was not available to be administered and acknowledged the physicians order needed clarification from the physician to administer one tablet or two tablets. No adverse outcomes were verbalized or recorded related to the R1's ondansetron not being available. Severity: 2 Scope: 1			
Y 0890 SS= D	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.**	Y 0890	1) As observed in the SOD, R2's file showed Omeprazole being discontinued and replaced by Pantoprazole via physician's order. However the change was not reflected in the MAR and both medications were initialed as being administered despite Caregiver correctly following the physician's order in practice.	10/13/2026

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	1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this		To correct this, Administrator will conduct additional training with the Caregiver on proper MAR maintenance with a focus on accuracy and integrity of each MAR. Furthermore, both Administrator and Owner will verbally check in with Caregiver during weekly MAR reviews on whether any changes may have happened to confirm consistency and accuracy of the written MAR. 2) To prevent this deficient practice from recurring, both Administrator and Owner will be adding verbal confirmation checks with Caregiver when doing weekly MAR reviews to ensure accuracy and integrity is being maintained. 3) Administrator and Owner will communicate weekly on how each other's MAR review went and confirm that they have both spoken with the Caregiver to ensure accuracy and consistency of the MAR. To monitor this, a new Weekly MAR Review Log will be present at the facility for Administrator/Owner and Caregiver to sign and date to show that they reviewed the MAR for the corresponding week. The MAR Review Log will have a checklist to ensure ease of review and kept for internal records and reference. 4) Both Administrator and Owner will be responsible for ensuring the plan of correction is implemented. 5) The corrective action took place on 10/13/26, with the Caregiver having received the additional MAR training. Furthermore, both Administrator and Owner have implemented the additional verbal confirmation with Caregiver during weekly MAR review along with communicating with each other to confirm the accuracy and integrity of the written MAR. Finally, the new MAR Review Log has been implemented at the facility as well. 6) For reference, facility will provide the new Weekly MAR Review Log and an updated MAR for R2 with name redacted that shows the corrections have been made.	

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	indication. Inspector Comments: Based on interview, observation and record review, the facility failed to ensure the Medication Administration Record (MAR) included accurate documentation for 1 of 9 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 08/31/23 with diagnoses including Anxiety and Diabetes. On 09/29/26 in the morning, R2's September 2026 MAR and physician's orders were reviewed, and R2's medication containers were observed. R2's file contained a physician's order dated 10/26/23 for omeprazole 20 milligram capsule, Take one capsule by mouth once daily. R2's September 2026 MAR documented omeprazole 20 milligram capsule, take one capsule by mouth once daily and was initialed as administered from 09/01/26 through 09/29/26. R2's medication container lacked evidence of omeprazole 20 milligram capsules. R2's file contained a physician's order dated 09/03/26 to discontinue R2's omeprazole 20 milligram capsules and start pantoprazole 40 milligram tablet.			

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	R2's September 2026 MAR documented pantoprazole 40 milligram tablet, take one tablet by mouth once daily and was initialed as being administered from 09/04/29 through 09/29/26 and was observed in R2's medication container. On 09/29/26 in the afternoon, a Caregiver acknowledged R2's omeprazole was inaccurately documented as being administered, and verbalized R2 did receive pantoprazole per the physician's order. Severity: 2 Scope: 1			