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 _____	**08/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CARE HOME LLC	**1012 PARADISE VIEW ST., HENDERSON, NEVADA ,89052**

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0000	Initial Comments Inspector Comments: The Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted in your facility on 08/14/25, in accordance with Nevada Administrative Code, Chapter 449 and Nevada Revised Statutes 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. Six resident records and five employee records were reviewed. The facility received a grade of B. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00074686 could not be substantiated. No regulatory deficiencies relating to the complaint could be identified. The investigation of the complaint included: Observation of the residents and their grooming/appearance. Interviews were conducted with residents, a Caregiver, the Manager and the Administrator. Clinical Record Review of residents, which included the resident of concern. Document Review including incident reports. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MINKYUNG LIM Title: Administrator Date: 01/28/2026

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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0515 SS= E	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 record review and interview, the facility failed to ensure 2 of 5 residents had a completed initial person-centered care plan. (Resident #2 and #5) Findings include: Resident #2 (R2) R2 was admitted on 08/07/25 with primary diagnoses including chronic obstruction pulmonary disease Stage 4, Type II diabetes, heart failure and atrial fibrillation. R2's record lacked documented evidence on an initial person-centered care plan. Resident #5 (R5) R5 was admitted on 03/31/25 with primary diagnoses including chronic kidney disease Stage 3, Alzheimer's disease and bronchiectasis. R5's record lacked documented evidence on an initial person-centered care plan. On 08/14/25 in the morning, the Manager confirmed the missing person-centered care plans for R2 and R5 and reported all residents were supposed to have an initial person-centered car plan completed. Severity: 2 Scope: 2	0515	1. We immediately completed the initial person-centered care plan for residents #2 and #5 (See attachment A). We discussed with staff the importance of having an initial person-centered care plan upon admission. Facility staff will collaborate with the resident, family, and other individuals involved in the resident's care to develop a person-centered service plan and will review it at least once a year, as required by regulation. 2. Management and the administrator will review residents' files more closely to ensure all residents have a completed initial person-center care plan upon admission and that care plans are reviewed at least annually. 3. We revised the new resident checklist to include the initial person-centered care plan to ensure all required documents are completed upon admission (See attachment A-1) 4. The manager and the administrator will be responsible for monitoring this corrective action. 5. Date 01/26/26.	01/26/2026

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0923 SS= E	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure over-the-counter (OTC) medications were labeled with the resident name and physician name for 2 of 5 residents. (Resident #2 and #5) Findings include: Resident #2 (R2) R2 was admitted on 08/07/25 with primary diagnoses including chronic obstruction pulmonary disease Stage 4, Type II diabetes, heart failure and atrial fibrillation. On 08/14/25 at 12:30 PM, observed a package of Fleet Laxative Saline Enema 7-19 grams/118 milliliters (ml), a package of Albuterol Sulfate 0.083% 2.5 milligrams (mg)/3 ml and a bottle of Polyethylene Glycol 3350 in R2's medication bin. The packages lacked a label that documented evidence of a resident name or physician name on them. Resident #5 (R5) R5 was admitted on 03/31/25 with primary diagnoses including chronic kidney disease Stage 3, Alzheimer's disease and bronchiectasis. On 08/14/25 at 12:45 PM, observed a package of Acetaminophen 650 mg in R5's medication bin. The package lacked a label that documented evidence of a resident name or physician name on it. On 08/14/25 in the afternoon, the Caregiver and Manager confirmed the missing resident and physician names on medication package labels for R2 and R5 and acknowledged there should be a resident and physician name on the OTC medication packages. Severity: 2 Scope: 2	0923	1. We discussed with the med techs their responsibility to ensure that all over-the-counter (OTC) medications and dietary supplements are clearly labeled with the contents, the name of the resident for whom they are prescribed, and the name of the prescribing physician, and that they are kept in their original containers until administered. The OTC bottles for Residents #2 and #5 are no longer in the facility, as both residents were deceased at the time this SOD was received (see Attachment B). All medications for Residents #2 and #5 have been properly destroyed (see Attachment B-1). Moving forward, we will ensure that all OTC medications are labeled with the resident's name and the prescribing physician's name. 2. The manager and the administrator will monitor all OTC medications monthly to ensure all OTC medication and dietary supplement bottles are properly labeled with the resident's name and the prescribing physician's name. 3. The manager and the administrator will review the MAR and all medications every 2 weeks to ensure ongoing compliance. 4. The manager and the administrator will be responsible for monitoring this corrective action. 5. Date 01/26/26.	01/26/2026

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0936 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 5 residents had complete tuberculin (TB) or QuantiFERON tests. (Resident #2 and #4) Findings include: Resident #2 (R2) R2 was admitted on 08/07/25 with primary diagnoses including chronic obstruction pulmonary disease Stage 4, Type II diabetes, heart failure and atrial fibrillation. R2's record lacked documented evidence of an initial two-step TB test. Resident #4 (R4) R4 was admitted on 05/03/25 with primary diagnoses including vascular dementia, Alzheimer's disease and hypertension. R4's record documented a one-step TB test with a 05/05/25 inject date and 05/08/25 read date, with a negative result. R4's record documented the second step TB test initiated on 05/08/25, not allowing wait time to inject the second step. On 08/14/25 in the morning, the Manager confirmed the lack of valid TB tests for R2 and R4 and acknowledged the correct wait time between step one and step two test for R4. Severity: 2 Scope: 2	0936	1. Resident #2 was under hospice care and had a 2-step TB test conducted. We contacted the hospice agency and requested either a Quantiferon test or a new 2-step TB test. The agency stated they would only perform a new second-step TB test, as the resident refused injections and a skin test had been conducted just three months prior (see Attachment C). We also requested records of any previous 2-step TB tests for the resident, but none were available. The resident's condition declined, and subsequently passed away. We reminded the hospice agency to ensure correct wait times in the future if performing TB testing for any of our residents. Resident #4 had difficulty communicating due to Alzheimer's disease and vascular dementia. Facility staff communicated with the resident’s son, who was the POA. The staff requested TB test records multiple times but did not receive them. The POA was noncompliant with facility regulations, making communication extremely challenging. Despite numerous attempts to address these matters, the POA did not comply, and management ultimately discharged the resident (see Attachment C-1). 2. Going forward, the facility will ensure that all residents complete either a 2-step TB test or a Quantiferon test upon admission. The revised new resident checklist, which includes guidance on the correct wait time between step one and step two, will be made available to all staff (see Attachment C-2). 3. The manager and the administrator will ensure that all TB test result are completed with the correct wait time between steps on and two for all residents. 4. The manager and the administrator will be responsible for monitoring this corrective action. 5. Date 01/26/26.	01/26/2026

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure doors leading to the exterior of the facility had audible alarms. Findings include: On 08/14/25 at 9:48 AM, the alarm on the door leading to the garage was not audible. At 9:48 AM, the Caregiver confirmed the alarm leading to the garage was working but was not activated. Severity: 2 Scope: 3	0991	1. We discussed with the staff the importance of keeping the alarm on the door leading to the garage activated at all times. The alarm was immediately activated so that it is audible whenever the door is opened (See attachment D). 2. Going forward, the facility will ensure that alarms installed on all doors that may be used to exit the facility remain active at all times. 3. The manager and the administrator will monitor all alarms more closely and check them during each visit to the facility. 4. The manager and the administrator will be responsible for monitoring this corrective action. 5. Date 01/26/26.	01/26/2026

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0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances, sharp objects and other items that could constitute a danger to a resident were inaccessible to residents. Findings include: On 08/14/25 at 9:44 AM, observed an unlocked drawer in the kitchen. The drawer contained a vegetable peeler and a knife sharpener. On 08/14/25 at 9:44 AM, observed a bottle of Ajax Cleaner, Lysol Cleaning Spray, Easy Off oven cleaner, a can of Ajax and other bottles of cleaning supplies in a lower kitchen cabinet. On 08/14/25 at 9:44 AM, the Caregiver confirmed the observation and reported the kitchen cabinet with the cleaning supplies and the kitchen drawer with the sharp objects should have been locked. Severity: 2 Scope: 3	0994	1. All staff of the facility have been aware that knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility to be inaccessible to the residents. We immediately cleaned the cabinet under the sink, and removed all cleaning supplies (See attachment E) and placed them in a laundry room, which will be locked at all times. The drawer and the kitchen cabinet will also remain locked at all times (See attachment E-1). 2. The manager and the administrator will inspect this area during each visit, and caregivers will check all areas requiring locks on a daily basis. 3. The manager and the administrator will conduct more thorough monitoring of the facility during each visit. 4. The manager and the administrator will be responsible for this corrective action. 5. Date 01/26/26	01/26/2026