

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>10745                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>10/21/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETHESDA CARE HOME          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5700 EXOTIC ROSETTE AVE, LAS VEGAS, NEVADA ,89139 |                                                                                                                          |                                                 |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br>RFG<br>0001-<br>Deficiencies | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG<br><br>RFG<br>0001-<br>Deficiencies                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                      |
|                                                                 | <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p> |                                                                                                |                                                                                                                          |                                                 |

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 Name: BASILIA CASIBANG Title: Administrator  
REPRESENTATIVE'S SIGNATURE

Date: 10/29/2025

Division of Public and Behavioral Health

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|                                                               | <p><b>of Nevada pursuant to NAC 433.384, and other applicable local and state laws.</b></p> <p>Inspector Comments:<br/>This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 10/21/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups.</p> <p>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.</p> <p>The census at the time of the survey was ten. Ten resident files and four employee files were reviewed.</p> <p>The facility received a grade of A.</p> <p>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.</p> <p>The following regulatory deficiencies were identified:</p> |                                                                                                       |                                                                                                                                                         |                                                        |
| Y 0930<br>SS= D                                               | <p><b>NAC 449.2749</b></p> <p><b>Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.</b></p> <p>1. A separate file must be</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Y 0930                                                                                                | <p><b>Resident #3 had the blood work done for TB Quantiferon test on 10/24/25 with results reported on 10/28/25. Test result was negative. File</b></p> | 10/29/2025                                             |

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|                                                               | <p>maintained for each resident of a residential facility and retained for at least 5 years after he 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:</p> <p>(a) The full name, address, date of birth and social security number of the resident.</p> <p>(b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him.</p> <p>(c) A statement of the resident's allergies, if any, and any special diet or medication he requires.</p> <p>(d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes:</p> <p>(1) A description of any medical conditions which require the performance of medical services;</p> <p>(2) The method in which those</p> |                                                                                                       | <p>attached.</p> <p>Administrator will be responsible in ensuring that required Initial and Annual TB requirements are completed for both Staff and Residents. Administrator will be using a Reminders/Notes phone Application to set up reminders to monitor renewal due dates.</p> |                                                        |

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|                                                        | <p>services must be performed; and</p> <p>(3) A statement of whether the resident is capable of performing the required medical services.</p> <p>(e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.</p> <p>(f) The types and amounts of protective supervision and personal services needed by the resident.</p> <p>(g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation:</p> <p>(1) Upon the admission of the resident;</p> <p>(2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and</p> <p>(3) In any event, not less than once each year.</p> <p>(h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative</p> |                                                                                                |                                                                                                                          |                                                 |

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|                                                        | <p>of the resident.</p> <p>(i)The name and telephone number of the vendors and medical professionals that provide services for the resident.</p> <p>(j) A document signed by the administrator of the facility when the resident permanently leaves the facility.</p> <p>2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death.</p> <p>3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau.</p> <p>Inspector Comments:<br/>Based on record review and interview, the</p> |                                                                                                |                                                                                                                          |                                                 |

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|                                                               | <p>facility failed to ensure 1 of 10 residents received a two-step tuberculosis (TB) test and an annual TB test (Resident #3).</p> <p>Findings include:</p> <p>Resident #3 (R3)</p> <p>R3 was admitted on 03/13/25, with polyneuropathy. R3's file revealed a negative chest x-ray on 06/08/24. R3's file lacked documented evidence of positive TB test.</p> <p>On 10/21/25 in the morning, the Administrator acknowledged the missing TB test and was unable to provide the documentation.</p> <p>Severity: 2      Scope: 1</p> |                                                                                                       |                                                                                                                          |                                                        |