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 _____	**03/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING ANGELS HENDERSON	**2249 EARLY FROST AVE, HENDERSON, NEVADA ,89052**

(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 survey initiated in your facility on 11/20/24 and completed on 03/11/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was eight. The sample size was four. The facility received a grade of C. There were three complaints investigated. Unsubstantiated: 1. Complaint #NV00071730 could not be substantiated. Substantiated: 2. Complaint #NV00072471 was substantiated. (See TAG Y853, Y878 and Y950) 3. Complaint #NV00073542 was substantiated. (See TAG Y853 and Y992) The investigation into the complaints included: Observations of grooming and physical appearance of residents, staffing ratio, use of oxygen, call bells, and interactions between staff and residents. Interviews with Caregivers, residents, Hospice Agency Director, Hospice Agency Registered Nurse, family representative, Owner and the Administrator. Clinical record review of residents, including residents of concern. Document review of facility policies and procedures, Staffing Schedules, Incident Reports and Resident Agreement. 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 deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARJOLIJN M KIRBY Title: Administrator Date: 05/16/2025

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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0160 SS= C	Advertising - NAC 449.205 Advertising and promotional materials. (NRS 449.0302) Advertising and promotional materials for a residential facility must be accurate and not misrepresent accommodations, services or programs offered by the facility. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure advertising was accurate and did not misrepresent services provided by the facility. Findings include: On 03/11/25 in the afternoon, a brochure at the facility's front desk in the living room indicated the facility provided care types including intellectual disabilities and assisted living. On 03/11/25 in the afternoon, the facility's website advertised premium group home services such as assistance with feeding tubes and assisted living service needs. As of 03/11/25, the facility did not have an endorsement for intellectual disabilities or assisted living to provide these types of services. Some resident bedrooms did not have private bathrooms. On 03/11/25 in the afternoon, the Owner confirmed the facility did not have endorsements for intellectual disabilities nor assisted living to be able to provide those services. Severity: 1 Scope: 3	0160	The website was updated on 05/13/25 to remove intellectual care, feeding tubes, and assisted living service needs. All brochures were thrown out, and owner to purchase new ones without the wording of intellectual care and assisted living. The Administrator and/or Designee will monitor for ongoing compliance.	05/13/2025

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0320 SS= F	Bedroom - Doors: Locks - NAC 449.220 Bedroom doors. (NRS 449.0302) 1. A bedroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge. Inspector Comments: Based on observation and interview, the facility failed to ensure resident bedroom doors and all bathroom doors were equipped with a single motion lock. Findings include: On 03/11/25 in the afternoon, observed all resident bedroom doors and all bathroom doors had locks which required more than one motion to unlock the doors leading to the interior of the facility. The door locks required residents to first turn the lock one direction, then turn the door handle downward to open the door. The resident bedroom and bathroom door locks did not provide facility security. On 03/11/25 at 2:10 PM, the Owner acknowledged there were double motion locks on the doors. Severity: 2 Scope: 3	0320	New single lever door handles without locks were purchased on 03/21/25 and installed on 03/25/25 on all resident bedrooms and bathrooms. Administrator and/or Designee will monitor for continued compliance going forward.	03/25/2025
0853 SS= E	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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This	0853	On 05/16/25 the Administrator held a retraining on Incident Reports, how to complete them properly, who to notify, when to send someone out, and documentation. A new incident report was provided for a better flow so important items would not be overlooked. A new Incident Binder was also created to help staff track reports so they are accessible and readily available for the administrator and/or surveyors to review. The Administrator and/or Designee will monitor for ongoing compliance.	05/16/2025

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	record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure Incident Reports documented the manner in which an accident or injury occurred for 2 of 4 residents, after an injury. (Resident #2 and #4) Findings include: Resident #2 (R2) R2 was admitted on 03/10/24 with diagnoses including major depressive disorder, hypertension, seizures, atherosclerosis heart disease of native coronary artery, hypothyroidism and dementia. An Incident Report dated 09/14/24, documented a head injury for R2. The report documented staff put an ice bag on R2's forehead for 20 minutes. The report did not include how R2 got the head injury. The report comments described R2's activity of throwing pillows off their bed, with no mention of a fall or other impact to the head. The report did not document when the Hospice agency or family were notified. A Hospice Visit Note for R2 dated 09/25/24, documented the nurse observed R2 with a healing bruise on the right side of the forehead and under both eyes. An Incident Report dated 09/14/24 lacked details to describe the following required areas on the form: - Details of Incident: There was not complete information of the injury, explaining the nature and site of the injury. -Site of Injury: There was no information on where the head injury was or the type of injury. -Was first aid given?: This section was left blank. - Referred to physician?: This section was left blank. -Family Notified?: This section did not document who was notified and when. - Follow Up: This section was left blank. - Suggestive Corrective Action, if Necessary: This section was left blank. -Additional Comments: This section documented R2's pillows on the bed. There was no specific documentation a fall occurred. On 11/20/24 in the morning, there was no documented evidence of any follow-up or monitoring of			

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	R2's injury. On 03/11/25 at 9:00 AM, the Owner confirmed R2 fell off the bed on 09/14/24. The Owner explained they would put pillows under R2's sheets to help keep R2 from falling off the bed, but R2 would take the pillows off the bed. The Owner reported on 09/14/24 R2 was in bed with pillows placed. The Caregiver went to assist another resident for about five minutes. The Caregiver heard a fall. R2 had turned over and fell out of the bed. R2 had no scratches, but had a lump on their forehead. Later a black eye developed around R2's right eye. Staff put ice on the lump. They called Hospice and the daughter. R2 was ok in a few days. There was no documentation of an Assessment done after R2's fall on 09/14/24, or monitoring of R2 by the Medication Technician on each shift, per facility policy. The facility's Resident Agreement documented record of all accidents, injuries or illness of residents shall be kept on file. These files will include documentation on daily activities, illness, medical contracts... On 11/20/24 in the afternoon, there were no policies or procedures available for review. On 03/11/25, the facility's Fall Response Procedure policy (updated 10/01/22), documented should a resident fall, staff will contact the physician for further instructions ... Should the resident have trauma resulting in deformity,... received obvious head or significant trauma the RCC or Med Tech summons EMS (911). Forty eight hours after any fall, and the resident remains in the home, the Med Tech on each shift will monitor the resident. An incident report is completed and given to the administrator. On 03/11/25, the facility's Medical Emergency policy (updated 10/01/22), documented the home summons emergency medical services (call 911), when the resident exhibits signs and symptoms of distress and/or emergency condition. Examples include: fall with deformity, severe pain or head injury;... An Incident Report is completed if the medical			

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	emergency is the result of a fall, accident, or other incident requiring the report ... If the Hospice nurse is present staff is not required to call 911. However the nurse must be in full agreement that summoning EMS is not a necessity ... On 03/11/25 at 1:40 PM, the Owner reported the protocol for resident falls was call Hospice first, home health, family and 911. In general, during an initial resident assessment, the Owner explained they ask if the resident has dementia and if there is a history of falls. Resident #4 (R4) R4 was admitted on 09/26/24, with a diagnoses including Alzheimer's disease. An Incident Report dated 09/14/24 lacked details to describe the following required areas on the form: - Details of Incident: There was no concise complete information of the injury, explaining the nature and site of the injury. - Site of Injury: There was no information on where the head injury was or the type of injury. -Referred to Physician?: This section documented no and documented the hospital name the resident was taken to. The report lacked if R4's physician was notified. -Family Notified?: This section did not document who was notified and when. - Follow Up: This section was left blank. - Additional Comments: This section documented R4's past behaviors. There was no documentation of a fall. On 03/11/25 at 12:30 PM, the Owner confirmed R4's hospitalization on 01/05/25, was due to a fall. The Owner noted the incident report did not document the circumstances of the fall, focusing solely on R4's behavioral history. Additionally, the report lacked information regarding the family member contacted and physician notification and the time of contact, which should have been included. Severity: 2 Scope: 2 Complaint #NV00072471 Complaint #NV00073542			
0878 SS= F	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-	0878	On 05/16/2025 The Administrator retrained the medtechs on medication management and the importance of administering medications per the doctors prescribed orders. Medtechs must give medications at	05/16/2025

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	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 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,		all times as prescribed even if the resident is sleeping. If there is an issue with the administration times medtechs are to notify the physician. Medtechs will also ensure that if a Hospice nurse administers medication that the Hospice Nurse completes the MAR. The Administrator and/or Designee will monitor for ongoing compliance by completing monthly medcart audits.	

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	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 document review, record review and interview, the facility failed to administer medications as ordered by a physician for 2 of 4 residents. (Resident #1 and #2) Findings include: Resident #1 (R1) R1 was admitted on 03/10/24 with diagnoses including senile degeneration of the brain, chronic kidney disease Stage 3, anxiety, depression. An Ultimate User Agreement (UUA) dated 03/10/24 and signed by the Power of Attorney (POA), authorized the facility to manage and administer R1's medications. Resident #2 (R2) R2 was admitted on 03/10/24 with diagnoses including major depressive disorder, hypertension, seizures, atherosclerosis heart disease of native coronary artery, hypothyroidism and dementia. An UUA dated 03/10/24 and signed by the POA, authorized the facility to manage and administer R2's medications. On 11/20/24 in the afternoon, the Hospice physician orders and the facility Medication Administration Record (MAR) for R1 and R2 documented the following: 10/05/24: Morphine 20 mg/ml administer 0.5 ml sublingually every 4 hours Lorazepam 2 mg/ml administer 0.5 ml sublingually every 4 hours On 11/20/24 in the afternoon, the October 2024 MAR documented administration times at 11 AM, 3 PM and 7 PM on 10/05/24. The MAR lacked documented evidence the Morphine and Lorazepam were administered for 11 PM, 3 AM, 7 AM on 10/05/24. 10/06/24: Morphine 20 mg/ml administer 0.75 ml sublingually every 4 hours Lorazepam 2 mg/ml administer 0.75 ml sublingually every 4 hours On 11/20/24 in the afternoon, the October 2024 MAR documented administration times at 11 AM, 3 PM and 7 PM on 10/06/24. The MAR lacked documented evidence the Morphine and			

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	Lorazepam were administered for 11 PM, 3 AM, 7 AM on 10/06/24. 10/07/24: Morphine 20 mg/ml administer 1 ml sublingually every 4 hours Lorazepam 2 mg/ml administer 1 ml sublingually every 4 hours On 11/20/24 in the afternoon, the October 2024 MAR documented administration times at 7 AM, 11 AM, 3 PM and 7 PM on 10/07/24. The MAR lacked documented evidence the Morphine and Lorazepam were administered for 11 PM and 3 AM on 10/07/24. 10/08/24: Morphine 20 mg/ml administer 1 ml sublingually every hour Lorazepam 2 mg/ml administer 1 ml sublingually every hour These orders for R1 and R2 were not documented on the October 2024 MAR and there was no documented evidence the medications were administered as ordered to R1 and R2. An Incident Report for R1 dated 10/08/24 by the Owner, documented the Hospice Nurse asked staff to administer the Morphine and Lorazepam to R1 and R2 even though they were both asleep. The Incident Report documented it was hard for staff to administer medications to R1 and R2 because R1 and R2 were asleep. The Incident Report documented the Hospice Nurse administered the medication to R1 and R2. However, there was no documented evidence to prove that the Hospice Nurse administered the medications in the middle of the night per the physician's orders. On 12/20/24 at 12:30 PM, the Hospice Nurse assigned to R1 and R2 reported the Owner would ask the RN to write physician orders as needed (PRN) so the facility staff could decide when they wanted to give the medications to R1 and R2. On 03/11/25 at 1:40 PM, the Owner reported for R1 and R2, if their medication was ordered for every eight hours, if R1 and R2 were asleep, the Owner did not administer the medications. For medications ordered every four hours, if R1 and R2 were asleep, the Owner did not administer the ordered medications. The Owner explained if R1 or R2 were sleeping, they were not in			

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	pain, and were not administered the medications per the physician's orders. For medications ordered every two hours, the facility did not administer the medications, but Hospice administered the medications. However, the Owner acknowledged the facility had not maintained documented evidence of Hospice's administration of R1 and R2's medications. The Resident Agreement documented resident records shall be kept for a period of five years. These files will include documentation on daily activities, illness and medications. An Ultimate User Agreement will be signed upon move in so the staff of this home will be able to manage the resident's medications as determined by the physician. Severity: 2 Scope: 3 Complaint #NV00072471			

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0950 SS= E	Hospice Care Responsibilities of Staff - NAC 449.275 Residential facility which provides residents with hospice care: Responsibilities of staff; retention of resident with special medical needs. (NRS 449.0302) 1. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to NAC 449.0186 for that resident. Inspector Comments: Based on record review and interview, the facility failed to obtain and retain a copy of a Hospice Plan of Care and hospice medication administration records for 2 of 4 residents receiving Hospice services, per the requirement. (Resident #1 and #2) Findings include: Resident #1 (R1) R1 was admitted on 03/10/24 with diagnoses including senile degeneration of the brain, chronic kidney disease Stage 3, anxiety, depression. R1 was accepted to receive Hospice care on 02/26/24. On 11/20/24, R1's record lacked documented evidence of Hospice records, including medication administration and the care provided by the Hospice agency. Resident #2 (R2) R2 was admitted on 03/10/24 with diagnoses including major depressive disorder, hypertension, seizures, atherosclerosis heart disease of native coronary artery, hypothyroidism and dementia. R2 was accepted to receive Hospice care on 02/26/24. On 11/20/24, R2's record lacked documented evidence of Hospice records, including medication administration and the care provided by the Hospice agency. On 11/20/24 in the afternoon, the Owner confirmed R1 and R2 were receiving Hospice care from an outside agency and there were no Hospice records onsite for R1 and R2. The Owner acknowledged there should have been Hospice records onsite for R1 and R2. Severity: 2 Scope: 2 Complaint #NV00072471	0950	Resident #1 passed away on 10/08/25 and Resident #2 passed away on 10/09/25. The owner provided the Hospice binders for resident #1 and resident #2 on 05/16/25. The owner and staff were retrained on 05/16/25 about maintaining Hospice records and filing promptly and placing the binders with records in areas of easy accessibility for survey reviews both current and past residents. The Administrator and/or Designee will monitor for ongoing compliance.	05/16/2025
0992	Alzheimer 's Care Standards for Safety -	0992	The Administrator retrained the owner and	05/16/202

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SS= F	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: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768. Inspector Comments: Based on record review and interview, the facility failed to ensure at least one member of the staff was awake at the facility at night. Findings include: The facility has an endorsement to provide care for residents diagnosed with Alzheimer ' s Disease and other forms of dementia. Resident #4 (R4) R4 was admitted on 09/26/24, with a diagnoses including Alzheimer's disease. The resident agreement signed by R4's responsible party on 09/26/24, documented basic service included continuous care, supervision, and observation for change in physical, mental, emotional, and social functioning with notification to the resident's family, physician, and other appropriate people and/or agency of the resident's needs. Nighttime supervision, medication management, and supervision in meeting necessary medical and dental needs. An incident report dated 01/05/25 at 12:45 PM, documented R4 went to the hospital. On 03/11/25 at 11:11 AM, the Owner reported R4 went to the hospital on 01/05/25 after sustaining a fall. The Owner reported they normally worked the night shift and		staff on the regulations of having at least one Med Tech/caregiver on duty and awake at all times on the overnight shift for resident safety. Staff must be awake and available at all times during the overnight shift and all other shifts. The Administrator and/or Designee will monitor for ongoing compliance.	5

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 _____	**03/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	sometimes when they were sitting in the living room during down times they would close their eyes. The Owner acknowledged on 01/05/25, the Owner fell asleep and woke up when hearing R4 fall on the floor. The Owner acknowledged the Owner should have been awake, per the Resident Agreement. Severity: 2 Scope: 3 Complaint #NV00073542			