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 _____	**10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOROTHY GRAHAM'S CARE HOME	**3180 ROWLAND ST, LAS VEGAS, NEVADA ,89108**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and complaint investigation survey completed at your facility on 10/09/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, four Category I and four Category II residents. The census at the time of the survey was eight. The sample size was five. The facility received a grade of B. There were two complaints investigated. Unsubstantiated: 1. Complaint #NV00074903 could not be substantiated. No regulatory deficiencies could be identified. 2. Complaint #12208 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaints included: Observation of grooming and physical appearance for residents, residents clothes and linens clean and no residents with bruises or skin tears. Interviews were conducted with residents, Caregivers, the Administrator a Registered Nurse and a Case Manager. Record Review of five records, which included the residents of concern. 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: GINALYN BALTAZAR-SUMBANG | Title: Administrator | Date: 12/09/2025

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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0053 SS= E	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on interview and record review, the facility failed to ensure resident files were complete and available for review for 3 of 8 residents (Resident #5, Resident #6 and Resident #7). Findings include: Resident #5 (R5) R5 was admitted on 08/22/25 with end stage renal disease. Review of R5s resident file revealed an incomplete record which did not contain documentation of a physical exam, care plan, tuberculosis (TB) test, intake packet, name of physician or resident rights. Resident #6 (R6) R6 was admitted on 08/22/24 with no diagnosis listed. Review of R6s resident file revealed an incomplete record which did not contain documentation of a physical exam, care plan, TB test, ultimate user agreement, intake packet or resident rights. Resident #7(R7) R7 was admitted on 08/20/25 with no diagnosis listed. Review of R7s resident file revealed an incomplete record which did not contain documentation of a physical exam, care plan, TB test, physicians name, ultimate user agreement, intake packet or resident rights. On 10/09/25, in the morning, the Administrator confirmed they had not completed and uploaded all documents in the resident files of R5, R6 and R7. Severity: 2 Scope: 2	0053	1. The Administrator immediately audited the Residents' files for R5, R6, R7 following the exit interview. All missing required documents were promptly obtained, completed, and inserted into the respective files. 2. The Administrator implemented a mandatory admission packet checklist (current and future) to ensure all documents are present, signed, dated, and complete. Additionally, the Administrator and Facility Staff will conduct randomly monthly audits of current resident files to ensure compliance. **3. Complete Date: 10/30/25** **4. See Attached: TAG Y 053**	10/30/2025

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure a physical exam and two step tuberculosis (TB) test was completed upon hire, for 1 of 4 employees (Employee #4). Findings include: E4 was hired on 10/09/25 as a Caregiver. Record review did not document completion of a two-step TB screening or physical exam for E4. On 10/09/25 in the morning, the Administrator was unable to provide documentation of a two-step TB screening or physical exam for E4. Severity: 2 Scope: 1	0102	1. Upon review, The Administrator confirmed that E#4 had previously completed a QuantiFERON TB test, but it had recently expired. The Administrator immediately instructed E#4 to obtain a current TB screening. In the meantime, a Signs and Symptoms screening was completed to make sure there were no active TB symptoms. Waiting for an updated TB test result. E4 is no longer in the facility. 2. The Administrator and Facility Staff will conduct a quarterly review of all current employee files to ensure compliance. **3. Complete Date: 11/10/25** **4. See Attached: TAG Y 890**	11/10/2025
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview and record review, the facility failed to ensure a background check was completed upon hire, through the Nevada Automated Background Check System (NABS) for 1 of 4 employees (Employee #4). Findings include: Employee #4 (E4) was hired on 04/22/25 as a Caregiver. E4's file and the NABS system revealed E4 had not completed a background check for this facility. On 10/09/25 in the morning, the Administrator was unable to provide documentation a background check for E4 had been completed. Severity: 2 Scope: 1	0104	1. The Administrator provided E#4 fingerprinting form to complete background check. However, E#4 has already resigned 2. The Administrator has implemented a new hire checklist to ensure all mandatory requirements including NABS background clearance are completed. The Administrator will conduct biannual audits on personnel files to ensure ongoing compliance. **3. Complete Date: 11/10/25** **4. See Attached:**	12/09/2025

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0890 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator 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. . Inspector Comments: Based on observation, interview and record review, the facility failed to ensure the Medication Administration Record (MAR) accurately documented all medications for 1 of 8 residents (Resident #3). Findings include: Resident #3 (R3) was admitted on 08/30/25 with diagnosis including dementia. On 10/09/25, in the morning, a bottle of Cranberry oral tablets was found in the medication bin of R3. Physicians order dated 08/30/25 documented Cranberry, 500 milligram oral capsules. Take one capsule two times a day. Cranberry capsules for R3 were not documented on the August or September 2025 MAR's. On 10/09/25, in the morning, the Administrator confirmed they forgot to list Cranberry capsules on R3's August and September 2025 MAR's. Severity: 2 Scope: 1	0890	1. The missing medication was immediately entered into the MAR. The Administrator then retrained all Facility Staff on making sure that all Resident medications have a Physician's order, are entered into the MAR, and available for administration as prescribed. 2. The Administrator will check the MAR weekly to make sure all medications have Physician's orders, are entered correctly and are available for administration. Any issues will be corrected immediately, and staff will be reminded as needed. **3. Complete Date: 10/09/25** **4. See Attached: TAG Y 890**	10/09/2025

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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 observations and interview, the facility failed to ensure all chemicals were properly secured. Findings include: On 10/09/25, in the morning, a door leading to the laundry room was found open and unsecured. Inside the laundry room multiple chemicals were found including glass cleaner, bleach, laundry detergent, Pine Sol cleaner and dish soap. On 10/09/25, in the morning, the Administrator confirmed the door to the laundry room was unlocked and multiple chemicals were unsecured and accessible to residents. Severity: 2 Scope: 3	0994	1. The Administrator immediately secured and locked the Laundry Room door, posted a "KEEP DOOR LOCKED AT ALL TIMES" sign, and reminded Facility Staff to make sure the laundry room and all chemical storage areas must always remain locked. 2. The Administrator reminded all Facility Staff that the Laundry Room and all chemical storage areas must stay always locked. The Facility Staff will also check these areas daily to ensure they remain secured. Any issues will be addressed right away. **3. Complete Date: 10/09/25** **4. See Attached: TAG Y 994**	10/09/2025
1825 SS= E	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and	1825	1. The Administrator immediately filed the 15 hours Infection Control Training certificates of E#3's personnel file 2. The Administrator implemented an annual training checklist to flag expiring requirements. The Administrator will also conduct biannual audit of all personnel files to ensure that all trainings are current and compliant. **3. Complete Date: 10/09/25** **4. See Attached: TAG Y 1895**	10/09/2025

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	prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary infection control staff member completed 15 hours of infection control training annually (Employee #3). Findings include: Employee #3 (E3) was hired on 01/21/25 as the Administrator. E3 was identified as the primary infection control manager for the facility. E3's file revealed no infection control training on file for E3. On 10/09/25 in the morning, the Administrator was unable to provide a total of 15 hours of annual approved infection control training in the past 12 months. Severity: 2 Scope: 2			