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 _____	**05/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE HOME	**7560 SILVER LEAF WAY, LAS VEGAS, NEVADA ,89147**

(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 completed at your facility on 05/15/25, 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 five. The facility received a grade of B. There was one complaint investigated: Substantiated: 1. Complaint #NV00073854 was substantiated. (See TAG Y0850, Y0853, and Y0860) Observations of facility staffing, residents receiving care and assistance, and a tour of the facility. Interviews were conducted with residents, the Caregiver, and the Administrator/Owner. Record Review of resident and employee records, which included the resident of concern. Document Review of polies and procedures. 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ROMEO V BALGAN Title: Administrator Date: 09/16/2025

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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0445 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 3. An exit door in a residential facility must not be equipped with a lock that requires a key to open it from the inside unless approved by the State Fire Marshal or his or her designee. Inspector Comments: Based on observation and interview, the facility failed to ensure a key was not required to exit the front door. Findings include: On 05/15/25 in the morning, the front door was observed to have a lock requiring a key for unlocking from the inside. On 05/15/25 in the morning, the Administrator/Owner was unaware of the fire code violation and explained the lock ' s purpose was to prevent residents from leaving without staff knowledge. Severity: 2 Scope: 3	0445	Tag 0445 Requirements and Precautions NAC 449.229 1). Immediate removal/replace of front door lock. 2). A systematic change by replacing the front door lock to ensure deficient practice does not recur. 3). The new lock is permanent. 4). The Administrator ensures the Plan of Correction is implemented. 5). 06/13/2025 Corrective action completed 6). See Appendix "A"	06/25/2025

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0515 SS= D	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 develop a person-centered service plan for 1 of 5 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/01/23, with diagnosis including diabetes, chronic obstructive pulmonary disorder, and history of falls. R1's file lacked a person-centered service plan and documentation of fall prevention. On 05/15/25 in the morning, the Administrator confirmed person-centered service plans were not developed for R1 and was not able to verbalize how they monitor R1 for fall prevention. Severity: 2 Scope: 1	0515	Tag 0515 Supervision and Treatment of Residents NAC 449.259 & R043-22 1). A Person-Centered Service Plan were developed for all Residents as required by the Bureau. Resident Ri has a plan for Person-centered service plan. 2). Each resident of the Care Facility must have a Person-centered service plan as required by the State to make sure about their information and sex orientation their address Physician, Diagnoses and other medical info. 3). A Facility Person-centered Service Plan was attached to his file to ensure deficient practice will not recur. 4). The Facility Administrator is responsible for ensuring the POC is implemented 5). 05/15/2025 corrective action was completed 6). See Appendix "B"	06/25/2025

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0592 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity; Inspector Comments: Based on observation and interview, the Administrator failed to ensure residents were treated with dignity and respect for 1 of 5 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/01/23, with diagnosis including diabetes, chronic obstructive pulmonary disorder, and history of falls. On 05/15/25 in the morning, R1 was sitting in their wheelchair in their bedroom. R1 had defecated on the floor. On 05/15/25 in the morning, the Administrator/Owner pushed R1 in their wheelchair out of their room into the dining room. The Administrator/Owner scolded R1 stating, "Don't do that again. That's embarrassing". The surveyor was present, and other residents were in the next room. On 05/15/25 in the morning, the Administrator/Owner communicated to the surveyor R1 was alert and knew how to use the bathroom independently. R1 should not defecate on the floor because R1 knew better than that. The Administrator/Owner did not believe the statement to R1 was disrespectful since the Administrator/Owner did not yell at R1. On 05/15/25 in the morning, R1 acknowledged what the Administrator/Owner said to R1 and reported that was just how the Administrator/Owner was towards residents. The (undated) Elder Abuse policy documented to be free from abuse and exploitation on the part of the residential staff. To be treated with respect and dignity. To live in a safe and comfortable environment. Severity: 2 Scope: 1 Complaint #NV00073854	0592	Tag 0592 Residents Rights NAC 449.268 1). The Administrator and the caregiver assisted the Resident and cleaned up the floor and well taken cared of immediately. 2). Caregivers will always provide what the resident needs and assure them of their hygiene and cleanliness in the facility 3). Residents must always be given more time to make sure everything is okay and in order 4). The Facility Administrator will be responsible for ensuring Plan of Correction is implemented 5). 05/15/25 The corrected action is completed 6). The Certificate of Completion for Elder Abuse Services Training was taken on **July 7,2025 uploaded 7/13/2025**	06/25/2025

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0850 SS= D	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) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on record review and interview, the facility failed to ensure emergency services, the responsible party, and the physician were contacted after 1 of 5 sampled residents sustained a fall (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/01/23, with diagnosis including diabetes, chronic obstructive pulmonary disorder, and history of falls. R1 was alert and oriented. A report from a state agency dated 03/11/25 documented the state agency called 911 on 03/11/25, after R1 sustained a fall on 03/06/25. The report indicated the Administrator/Owner discouraged R1 from going to the hospital while the state agency was on-site. On 03/11/25, an emergency department discharge report documented a diagnosis of shoulder pain and muscle strain. On 05/15/25 in the morning, R1 reported falling a couple months ago out of their wheelchair and sustained a fall outside on the front patio, where they lay on the cement for an unknown period of time. R1 reported they called for help until a neighbor found them. R1 indicated they were in pain and explained R1 hit their head on a flowerpot outside. R1 mentioned the neighbor got the Caregiver to come outside. The Caregiver did not stay with them and left them alone on the front patio. On	0850	Tag 0850 NAC 449.274 Medical Care of Resident after Illness 1). Resident R1 has been brought back inside the facility right away, The administrator asked if them is alright and resident said yes, Administrator ask the resident if they wants to go to Hospital but resident declined and said there is no pain and was alright. **A House Rule has been added. "If a Resident falls head first and injury appears, 911 Paramedics need to be called.** 2). When a resident falls and landed head first, 911 Paramedics need to be called, It also needs to report to the Resident PCP, Doctor, relatives and the ADSD Social Worker assigned and Injury report must be filed to the incident and attached to his file 3). Caregivers need to see the Residents they are safe and ensure the deficient practice will not recur. 4). Facility Administrator is responsible for ensuring the Plan of Correction is implemented. 5). 03/062025 Corrective date of action completed. 6). Attached please find the Incident Report reported to ADSD Case Manager on the same day. See Appendix "C".	07/03/2025

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	05/15/25 in the morning, the Caregiver on duty reported they were on duty when R1 fell and was unaware how long R1 remained outside on the ground. The Caregiver reported 911 was not called and they waited for the Administrator/Owner to arrive and assist R1 off the ground. The Caregiver acknowledged leaving R1 alone outside on the ground for a period of time. On 05/15/25 in the morning, the Administrator/Owner explained the Caregiver could not assist R1 off the ground alone and requested the Administrator/Owner to come to the facility to help. The Administrator/Owner verbalized it took them ten minutes to get to the facility to assist the resident. The Administrator/Owner reported they did not ask R1 if R1 had hit their head and R1 refused hospital treatment. The Administrator/Owner indicated if a head injury had occurred, hospital visits were not always necessary. The Administrator could not explain when a call to 911 would be necessary. Hospital records documented R1's visit was for shoulder pain and muscle strain. R1 was discharged on 03/11/25. R1's file lacked documented evidence if the physician or next of kin were notified of the fall. The Administrator/Owner did not follow the incident report policy and acknowledged 911 was not called by the facility and was called by a state agency on 03/11/25. The (undated) Incident Report Policy documented an incident was either an accident or illness or both. If an incident occurred, then 911 emergency and paramedics need to be called right away and to report it to their next of kin and doctor. Severity: 2 Scope: 1 Complaint #NV00073854			
0853 SS= D	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	0853	Tag 853 Medical Care of Resident After Illness NAC 449.274 1). All the necessary protocols and requirements were met on the incident 2). Incident Reports was done and they are very much important to serve as an	07/03/2025

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	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 record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report was completed for 1 of 5 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/01/23, with diagnosis including diabetes, chronic obstructive pulmonary disorder, and history of falls. Per a state agency report, R1 sustained a fall outside on the front patio on 03/06/25, at an unknown time, the file lacked an incident report documenting the following information after the fall occurred: (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. On 05/15/25 in the morning, the Administrator/Owner reported the standard procedure required documenting any resident incident, such as a fall, in an incident report. The Administrator/Owner was unable to provide documented evidence showing an incident report had been completed for R1's fall. The (undated) Incident Report Policy documented an incident report was either an accident or		information of any incident or accident in the Facility. 3). **Incident Reports will be completed and monitored for all future incidents and should be kept in the Residents File.** 4). The Facility Administrator is responsible and ensure Resident's fall must be reported to Resident's Doctor, Assigned ADSD Social Worker, relatives and noted the times, dates, witnesses are assistance are required. 5). 03/06/25 Completion date 6). See Appendix "C"	

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	illness or both. An incident report form should document the name of the resident, the date and time the incident occurred, who discovered the incident, the description of the incident, and to report it to their next of kin and doctor. Severity: 2 Scope: 1 Complaint #NV00073854			
0860 SS= D	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) 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he or she requires. (b) Monitor the ability of the resident to care for his or her own health conditions and document in writing any significant change in his or her ability to care for those conditions. Inspector Comments: Based on observation and interview, the facility failed to ensure a Caregiver provided oversight to residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/01/23, with diagnosis including diabetes, chronic obstructive pulmonary disorder, and history of falls. The Mission documented on the page of R1's resident agreement dated 09/01/23, documented 24-hour supervision and high-quality care. On 03/06/25, at an unknown time, R1 sustained a fall outside on the front patio. On 05/15/25 in the morning, R1 reported falling out of their wheelchair and sustaining a fall outside on the front patio, where they lay on the cement for an unknown period of time. R1 indicated they called for help until a neighbor found them. The neighbor got the Caregiver to come outside. The Caregiver did not stay with them and left them alone on the front patio. On 05/15/25 in the morning, the state surveyor was at the facility from 8:45 AM - 11:00 AM. During this time frame, there was one Caregiver on duty and the Administrator/Owner came to the home. The Caregiver stayed in the	0860	Tag 860 Medical Care of Resident after Illness NAC 449.274 1). All the necessary protocols and requirements were met. 2). If a resident falls and injury is observed, 911 Paramedics must be called. An incident Report must be completed and monitored for all future incidents and kept in Residents file. Doctor, Social Worker and relative must be reported. 3). **Caregivers need to ensure that Residents are okay and checked frequently** 4 The Facility Administrator is responsible for ensuring the Plan of Corrections is implemented. 5 October 15, 2025	07/03/2025

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	kitchen while the Administrator/Owner sat with the surveyor at the kitchen table. Neither the Caregiver nor the Administrator/Owner checked on the residents who remained in their bedrooms during the survey. The state surveyor had to inform the caregiver that a resident had a bowel movement on their bedroom floor and then later that there was still feces on the floor. On 05/15/25 in the morning, an anonymous resident reported the Caregiver came in three times a day to deliver meals. The resident explained their calls for help often went unanswered. If the resident needed assistance between those times, the resident had to find the Caregiver by leaving their room to locate the caregiver. On 05/15/25 in the morning, the Caregiver on duty reported being on duty when R1 fell and was unaware how long R1 remained outside on the ground. The Caregiver acknowledged leaving R1 alone outside. When asked how often they checked on residents, the Caregiver replied they checked on residents, but were unable to provide a timeframe. The Caregiver admitted not checking on residents during the survey. On 05/15/25 in the morning, the Administrator/Owner acknowledged the Caregiver did not check on residents and could not provide a timeframe for how often checks should occur. Severity: 2 Scope: 1 Complaint #NV00073854			

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0938 SS= D	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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an annual Activities of Daily Living (ADL) Assessment was completed for 1 of 5 sampled residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 09/01/23, with diagnosis including diabetes, chronic obstructive pulmonary disorder, and history of falls. R1's file documented an initial ADL Assessment dated 09/03/23. R1's file lacked documented evidence of an annual ADL Assessment. On 05/15/25 in the morning, the Administrator confirmed the missing annual ADL Assessment for R1 and acknowledged R1's annual ADL was not completed. Severity: 2 Scope: 1	0938	Tag 0938 Maintenance and Contents of Separate File NAC 449.2749 1). An ADL Assessment was completed for Resident 1 since arriving in the facility since 2023. 2) Resident 1 ADL was found and attached to his file 3). All Residents must have ADLs annually and be seen their Doctors or Primary Care Physicians for their annual check-up 4). The Facility Administrator with the assistance of Facility Manager will work hand in hand to make sure all the Residents needs are met, all the residents rights are employed to a better care and understanding 5). 06/20/25 6). See attached Appendix "D"	06/25/2025