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 _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY CARE CENTRE	**1807 E LONG STREET, CARSON CITY, NEVADA ,89701**

(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 an annual State Licensure and complaint survey conducted at your facility on 01/28/2025, in accordance with Nevada Administrative Code (NAC) 449, Residential Facility for Groups. The facility is licensed for 38 residential facility for group beds for Category II, non-Alzheimer's residents. The census at the time of the survey was 34. Ten resident records were reviewed, and 10 employee records were reviewed. The facility received a grade of C. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. There were four complaints investigated. Complaint #NV00070420 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: An unlicensed caregiver administered medications to a resident. Allegation #2: A resident's guardian was not notified of alleged sexual abuse. The investigation into the allegations included: Observations of residents and staff in common areas and medication administration. Interviews were conducted with four residents, a cook and a manager/medication technician of the facility. Clinical record review included the standard physician placement determination, the ultimate user agreement, documentation of a power of attorney and guardianship, an incident report, and	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EVA BELTEJAR Title: Owner Date: 07/22/2025

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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	resident medication administration records. Personnel record review included medication technician medication administration training. Facility documentation review included resident house rules. Complaint #NV00073163 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: An unlicensed caregiver administered medications to a resident. Allegation #2: Residents were not provided with adequate food Allegation #3: The time between dinner and breakfast the next day exceeded 14 hours. Allegation #4: Residents were not provided with proper bedding. Allegation #5: Windows were screwed shut and unable to be opened. Allegation #6: Staff convicted of abuse continued to work at the facility. The investigation into the allegations included: Observations of residents and staff in common areas, resident bedrooms, operable windows, bedframes and bedding, lunch service, menu postings, meal time postings, and medication administration. Interviews were conducted with four residents, a cook and a manager/medication technician of the facility. Clinical record review included the standard physician placement determination, the ultimate user agreement, and resident medication administration records. Personnel record review included medication technician medication administration training, abuse prevention training, and clearance in Nevada's Automated Background Check System (NABS). Facility documentation review included resident house rules. CPT #NV00071266 with the allegation a resident lost an envelope of money on an outing with facility staff could not be substantiated due to a lack of evidence. Investigation into the allegation included: Observation of staff and residents interacting in common areas and staff providing care to residents. Interviews with residents, to include the resident of concern, a caregiver, and the Owner.			

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	Clinical record review included service plans and history and physical. Document review included a signed acknowledgment of Information of Services and Resident Rights. CPT #NV00071001 with the allegation the facility was overpaid for a resident's rental rate and refund was refused was substantiated for financial abuse (see Tag Y590). 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:			
0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training.	0065	1.Employee #2 has completed the required eight hours of annual training specific to the care of the elderly or disabled but was not seen during time of survey. The documentation has been filed in the correct spot in the employee binder for easy access. 2.A tracking system will be implemented in a outlook calendar to monitor all employee training requirements on a rolling basis, with alerts set 30 days before annual training deadlines. Additionally, annual personnel audits will be conducted each quarter to catch and correct deficiencies proactively. 3.The office manager will review the training tracker monthly to verify that all required training is current. Any discrepancies will be flagged and addressed immediately. 4.Office manager and owner will be responsible for implementation of POI. 5.Corrective action completed on 7.10.25	07/10/2025

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	Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 2 of 10 employees, working at the facility one year or greater, completed at least eight hours of annual Caregiver training (Employee #5). Findings include: On 01/28/2025 at approximately 9:00 AM, the Office Manager was provided the Personnel Check List to complete for ten sampled employees. On 01/28/2025 at 3:30 PM, the Office Manager provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as a Medication Technician with a start date of 11/01/2023. Employee #2's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. On 01/28/2025 at 3:30 PM, the Office Manager provided the Attestation of Compliance form, signed and dated 01/28/2025, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Office Manager verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1		6.All Supporting documents uploaded. 7.A full audit of all employee personnel files has been conducted to ensure annual training is current for every staff member.	
0100 SS= D	Personnel File - NAC 449.200 & R043-22 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: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee, including, without limitation: (1) Certificates of completion for all training completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the	0100	1. The Administrator's complete personnel file, including required personal, employment, training, and reference documentation, has been collected and is now securely maintained on-site in accordance with NAC 449 regulations. The file will be reviewed to ensure all required documents, such as certificates and reference checks, are present and complete. 2.All administrative staff files will now be stored on-site in a secure, centralized personnel records cabinet. A facility policy will be implemented requiring all employee files, including those of executive-level staff, to remain on facility premises and accessible for review at any time.	07/02/2025

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	training or an outline of the training; (e) Evidence that the references supplied by the employee were checked by the residential facility. Inspector Comments: Based on observation and interview, the facility failed to maintain a separate personnel file kept for each member of the staff of the facility. Findings include: On 01/28/2025 at 11:30 AM, Manager/Medication Technician (Employee #2 and Designee) verbalized the Administrator's (Employee #1) personnel file was not held by the facility, but was in the Administrator's possession. No documentation was available for inspection including: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee, including, without limitation: (1) Certificates of completion for all training completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the training or an outline of the training; (e) Evidence that the references supplied by the employee were checked by the residential facility. Severity: 2 Scope: 1		3.Quarterly internal audits of all employee files, including the Administrator's, will be conducted by the Office Manager to ensure all required documentation is present and up to date. Missing or outdated documents will be flagged and resolved immediately. 4.Office Manager and Owner will be responsible for implementation of POI. 5.Date completed July 2, 2025 6.All pertinent documentation uploaded. 7.A full audit of all employee files, including upper management and on-call staff, will be conducted to confirm compliance with all personnel documentation requirements. All missing documents has been gathered and filed promptly, and findings will be used to guide staff training on compliance standards. Administrator's File on record and filed: Hire Date: Jan. 1, 2003 until current date Administrator's License # 9035, expiration date November 2026 Administrator's Training Records uploaded.	

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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 document review and interview, the facility failed to ensure 2 of 10 employees obtained a tuberculosis (TB) screening (Employee #1 and Employee #4). Findings include: On 01/28/2025 at approximately 9:00 AM, the Office Manager was provided the Personnel Check List to complete for ten sampled employees. On 01/28/2025 at 3:30 PM, the Office Manager provided the completed form with the following information: Employee #1 was hired as Administrator. The facility was unable to provide the hire date. Employee #1 personnel file lacked documented evidence of an annual TB testing. Employee #4 Employee #4 was hired at the facility on 12/20/2024 as a Caregiver. Employee #4 personnel file lacked documented evidence of a TB test. On 01/28/2025 at 3:30 PM, the Office Manager provided the Attestation of Compliance form, signed and dated 01/28/2025, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Office Manager verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0102	1.The personnel files for Employee #1 and Employee #4 has been immediately updated to include the missing TB test documentation. The official hire date for Employee #1 will be confirmed and added to the personnel file to ensure compliance with regulatory requirements. 2.A standardized new hire checklist has been implemented to ensure all required documentation, including TB testing and hire dates, is completed and filed before an employee begins work. All current employee files will also be audited for any missing health or employment documentation. 3.The Office Manager will perform monthly reviews of all personnel files to confirm that TB testing and employment documentation remain up to date. Any deficiencies identified during review will be corrected immediately. 4.Office Manager and Owner will be responsible for implementation of POI. 5.The date the corrective action has been completed: June 5, 2025. 6.All pertinent documentation has been uploaded. 7.A full review of all employee personnel files will be conducted to identify and correct any additional missing or outdated TB tests or employment documentation. Staff will be retrained on documentation standards to prevent future issues.	06/05/2025

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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 personnel file review, document review and interview, the facility failed to ensure 1 of 10 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.123 (Employee #1). Findings include: On 01/28/2025 at approximately 9:00 AM, the Office Manager was provided the Personnel Check List to complete for ten sampled employees. On 01/28/2025 at 3:30 PM, the Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired as Administrator. The facility was unable to provide the hire date. Employee #1's personnel file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History, a Criminal History Statement, and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 01/28/2025 at 2:05 PM, the Manager/Medication Technician (Employee #2 and Designee) verbalized Employee #1's personnel file was not on site and in the possession of Employee #1 at home. A Surveyor Report for the facility, accessed on 01/27/2025 at 9:49 AM from NABS lacked documented evidence of Employee #1 listed as a former, current, or pending employee. On 01/28/2025 at 3:30 PM, the Office Manager provided the Attestation of Compliance form, signed and dated 01/28/2025, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Office Manager verbalized attesting to the accuracy of the Personnel Checklist	0104	1.The Administrator’s full personnel file has been retrieved and is now stored securely on-site. Fingerprints have been submitted to the Central Repository for Nevada Records of Criminal History, the Criminal History Statement has been completed, and a NABS clearance letter has been obtained and added to the file. 2.A new policy has been re-enforced requiring all personnel files, including those of administrators and management, to be always maintained on-site. Additionally, no employee will be considered active until all background clearance documentation has been completed and filed. 3.The Office Manager will conduct monthly audits of all personnel files to ensure that fingerprint submissions, NABS clearance, and other background check documents are present and current. A tracking log will be maintained for new hires to ensure timely compliance. 4.Office Manager and Owner will be responsible for implementation of POI. 5.Date corrective action completed if June 15, 2025. 6.All pertinent documentation has been uploaded. 7.A full review of all current employee files has been completed to identify any missing or incomplete background documentation. Any discrepancies will be addressed immediately, and employees will not be permitted to continue working until all required clearances are verified and on file.	06/15/2025

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	Form self-attestation. Severity: 2 Scope: 1			

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0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on document review and interview, the facility failed to ensure 2 of 10 employees were currently certified to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #1 and Employee #4). Findings include: On 01/28/2025 at approximately 9:00 AM, the Office Manager was provided the Personnel Check List to complete for ten sampled employees. On 01/28/2025 at 3:30 PM, the Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired at the facility as Administrator. The facility was unable to provide the hire date. Employee #1's personnel file lacked documented evidence the employee had a current CPR and First Aid certification. Employee #4 Employee #4 was hired as a Caregiver on 12/20/2024. Employee #4 personnel file had no documented evidence the employee had a current CPR and First Aid Certification. On 01/28/2025 at 3:30 PM, the Office Manager provided the Attestation of Compliance form, signed and dated 01/28/2025, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Office Manager verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0450	1.The hire date for Employee #1 has been verified and added to the personnel file. Both Employee #1 and Employee #4 have completed current CPR and First Aid training, and certificates have been obtained and filed accordingly. 2.A mandatory checklist will be completed at the time of hire to ensure CPR/First Aid certifications are obtained prior to the employee's start date. Certification renewals will be tracked using a calendar reminder system with alerts set 60 days prior to expiration. 3.The Office Manager will conduct quarterly audits of personnel files to verify that all staff certifications are current and that documentation such as hire dates and credentials are present. Any lapses will be immediately corrected and staff placed on temporary leave if needed. 4.Office Manager and Owner will be responsible for implementation of POI. 5.The date the corrective action has been completed: 5.15.2025 6.All pertinent documentation has been uploaded. 7.A full personnel file audit has been completed to ensure all employees, including part-time and on-call staff, have valid CPR and First Aid certifications. Any gaps will be resolved by scheduling immediate recertification or removing staff from the schedule until compliance is met.	05/15/2025

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0590 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: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on record review, interview, and document review the facility failed to ensure a resident was protected from financial exploitation when the Administrator accepted payments of $4500 per month from a resident's Trust, and $1500 per month by the Medicaid waiver program, totaling payments of $6000 per month despite the agreement of $4500 per month for 1 of 4 complaint investigation residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 03/15/2022, with a diagnosis of schizoaffective disorder. Resident #11's Admission Agreement dated 03/07/2022, lacked documentation of the monthly rate to be paid. A Letter of Agreement dated 03/2022, from a local hospital to the facility, documented Resident #11 would be discharged to the facility on 03/10/2022 and the group home rate was $4000 per month. An email from the facility Administrator to the resident's Trust, dated 07/06/2022, documented the monthly rate would be increased to $4500 per month. A letter from an attorney representing Resident #11's Trust dated 02/05/2024, documented a demand to resolve the overpayment of funds to the facility beginning in 2022. Resident #11's Guardian discovered the facility received payments from both Medicaid and the resident's Trust account. The Trust paid $4500 per month from July 2022 through September of 2023, in addition to Medicaid making payments of $1500 per month to the facility. The letter	0590	1. This matter was brought before the court and hasbeen legally settled between all parties involved. The Administrator has repaidthe $7,500 settlement amount as ordered, and a revised Admission Agreementreflecting a clearly documented monthly rate has been implemented and signed byall relevant parties. 2. This issued occurred under old ownership and allprior documents used under that management have been updated or replaced. A newfinancial tracking and billing protocol has been implemented that ensures allincoming payments from any source are reconciled against the signed AdmissionAgreements. All agreements now explicitly define total monthly charges anddesignate the responsible payors. No dual billing from different sources willbe accepted without documented and pre-approved agreements. The new admissionagreement clearly defines what is due per resident. Financial resourcesavailable are clearly explained to residents and guardians to ensuretransparency. 3. All new admission documents will be reviewed andsigned by the office manager and payment authorizations utilized to ensuretransparency of financial matters. The Office Manager will conduct monthlyreviews of resident billing records, comparing payment sources against signedagreements. The Owner will conduct quarterly audits to verify financialcompliance and prevent any unauthorized dual	03/06/2025

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	requested the facility return an amount of $33,500 which was overpaid to the facility by the Trust. On 01/28/2025 at 12:37 PM, the Administrator verbalized the resident was admitted to the facility in March 2022 and the monthly rate was $4000 per month. After the resident had been at the facility for a few months, the facility notified the resident's Trust in July 2022, the resident's monthly rate would be increased to $4500 due to the resident's level of care needed. The Trust began making payments of $4500 per month after the notification. The resident was approved by the Medicaid Waiver Program for payments of $1500 per month. The facility began receiving payments of $1500 per month from Medicaid, in addition to the $4500 per month paid by the resident's Trust. The Administrator explained the Administrator did not feel the facility was being overpaid because if the resident had been admitted to a locked facility, the monthly rate of pay would be $6000 per month, so it was appropriate for the facility to receive $6000 per month for Resident #11. The Administrator verbalized there was no documentation of the monthly rate increase to $6000 per month, nor was there documentation of notice to the resident's Trust of the rate increase, and insisted the payments from Medicaid were not an overpayment. The Administrator verbalized they did not invoice the Trust for the resident's monthly rates, and only accepted the money sent. The Administrator insisted the Trust knew Medicaid was sending payments of $1500 per month and continued to send payments of $4500 per month knowingly, thus accepting the monthly rate charged at $6000 per month. The Administrator verbalized the Trust applied for Medicaid on the resident's behalf and agreed to pay $4500 in addition to the $1500 per month paid by Medicaid. The Administrator confirmed the facility did not have any documentation of an agreement for the facility to receive $6000 per month to		payments or rate changes. 4. Office Manager and Owner will be responsible forimplementation of POI. 5. Date plan of correction implemented 3.6.2025. 6. All pertinent documentation has been uploaded. 7. All resident agreements and billing historieshave been reviewed to identify any other potential discrepancies. No additionaloverpayments have been found. All residents now have updated admissionagreements that clearly specify the monthly rate and payment source, and allstaff have been retrained on payment handling and documentation procedures.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		A. BUILDING _____ B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	care for Resident #11. On 01/31/2025 at 1:31 PM, a Guardian Case Manager on behalf of the resident's Trust verbalized they had discovered Medicaid was approved and funds in the amount of $1500 were being paid to the facility in addition to the $4500 the Trust was paying monthly for Resident #11. The Trust requested a refund from the facility and the facility refused to respond. The Guardian Case Manager believed the facility applied for Medicaid on the resident's behalf and failed to notify the Trust of the monthly Medicaid payments. The Guardian Case Manager confirmed the agreed upon monthly rate to the facility was $4500 in total, not $6000. The Trust had to take the facility to court regarding the overpayment and the court issued a determination for the facility to settle the overpayment. The amount of the settlement, paid to the Trust, was $7500 in July 2024. The Guardian Case Manager explained the facility could not provide an accurate accounting of the funds received, and the true amount of overpayment could not be determined by the court. The facility policy titled "Policy on Admission," undated, documented cost of room and board must be agreed upon in writing before admission to the facility. Complaint #NV0007001 Severity: 2 Scope: 1		Case for Strickland: Resident #11 case settled in court on June 24, 2024. Uploaded recap of case and settlement check. Manager is in charge of properly documenting all agreements on rent or fees.	

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0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to post the facility's monthly rates for services in a conspicuous place in the facility. Findings include: On 02/28/2025 at 2:05 PM, the facility's rates for services provided were not posted in the facility. On 02/28/2025 at 2:05 PM, the Designee) confirmed the information was not posted. Severity: 1 Scope: 3	0644	1.The facility's current monthly rates for services have been printed and posted in a clearly visible and accessible location in the facility's main entry area, in compliance with state requirements. 2.A policy has been established requiring that any changes to monthly rates must be updated and posted within 24 hours of becoming effective. Posting of rates will now be included in the facility’s compliance checklist reviewed monthly by the Office Manager. 3.The Office Manager will verify during monthly facility walkthroughs that the most current service rates are visibly posted. This will be documented and signed off in the facility’s ongoing compliance log. 4.Office Manager and Owner will be responsible for implementation of POI. 5.The date the corrective action has been completed: June 7,2025 6.All pertinent documentation has been uploaded. 7.The facility conducted a review of all required postings (resident rights, emergency numbers, licensing, etc.) to ensure all are visible and current. Staff have been retrained on posting obligations as part of regulatory compliance protocols	06/07/2025

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0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 and R043-22 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) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on interview and clinical record review, the facility failed to ensure an initial physical examination with a review of systems was completed prior to admission for 2 of 10 sampled residents (Resident #5 and #1). Findings include: Resident #5 Resident #5 was admitted to the facility on 07/12/2024, with a primary diagnosis of schizophrenia. Resident #5's clinical record included a physical examination completed on 07/16/2024, four days after admission to the facility. On 01/28/2025 at 1:06 PM, the Manager verbalized initial physical examinations were to be completed before admitting to the facility and confirmed Resident #5's initial physical examination was completed late. Resident #1 Resident #1 was admitted to the facility on 11/11/2024, with diagnoses including disorder depressive, acute kidney failure, Parkinson, osteoporosis, and malnutrition. Resident #1's clinical record lacked documented evidence of a physical examination completed prior to admission to the facility. On 01/28/2025 at 10:41 AM, the Manager confirmed the resident's initial physical examination was not located in the resident's file. Severity: 2 Scope: 1	0859	1.The facility has obtained and placed the missing initial physical examination for Resident #1 in the resident's clinical record. A late entry note has been added for Resident #5 acknowledging the delayed exam, and both records now reflect accurate documentation of the resident's health status at admission. 2.A revised admission checklist has been implemented requiring documented evidence of a completed physical exam with review of systems prior to move-in. Facility created internal initial exam form to be completed prior to admission by Resident's current primary. Admissions will not be finalized unless the physical is received and verified by the Office Manager. 3.The Office Manager will review each new admission packet to confirm the physical examination is completed and on file before the resident is accepted. A quarterly audit of admissions will be conducted by the Owner to ensure ongoing compliance. 4.Office Manager and Owner will be responsible for implementation of POI. 5.Date of correction: June 30,2025 6.All pertinent documentation has been uploaded. 7.A facility-wide audit of all resident files admitted within the past 12 months has been completed to confirm initial physicals are on file. Any missing documentation has been requested from the appropriate medical providers and added to the records.	06/30/2025

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0936 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: (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 1 of 10 residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 01/10/2025, with diagnoses including osteoporosis, persistent depressive disorder, hypertension, and hyperlipidemia. Resident #7's clinical record lacked documented evidence of an initial two-step TB test upon admission to the facility. On 01/28/2025 at 12:52 PM, the Manager confirmed TB testing for Residents #7 had not been completed on time. Severity: 2 Scope: 1	0936	1.The two-step TB test for Resident #7 has been completed, and the documentation has been placed in the resident's clinical record. A note has been added to reflect the late completion and corrective action taken. 2.The admission protocol that requires verification of completed two-step TB testing before a resident is officially admitted has been re-trained and emphasized. TB testing compliance has been added to the pre-admission checklist. Facility has compiled a list of resources to obtain TB Test for new admissions for family members and 3.The Office Manager will review the TB test documentation for all new residents as part of the admission approval process. A monthly audit of resident records will be conducted to ensure continued compliance. 4.Office Manager and Owner will be responsible for implementation of POI. 5.The date the corrective action completed: 6.25.2025 6.All pertinent documentation has been uploaded. 7.A full audit of all resident records from the past 12 months has been conducted to verify completion of required TB testing. Any missing or incomplete tests have been scheduled and documented to bring all records into full compliance.	06/25/2025