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 _____	**03/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CREST HOME CARE	**4462 FARMCREST DRIVE, LAS VEGAS, NEVADA ,89121**

(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 and an annual State Licensure survey completed at your facility on 03/03/2026, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with Mental Illness, Category II residents. The census at the time of the survey was nine. Nine resident files and six employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: Complaint #NV00074833 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observation of facility environment, physical appearance of residents, meal observation and tour of the facility. Interviews were conducted with residents, Caregiver and the Owner of the facility. Clinical Record Review of nine records. Document Review included ultimate user agreement, physicans placement determination, medication policy, and active daily living logs. 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		
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-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or	0878	The caregiver immediately reviewed the medication order and corrected the Medication Administration Record (MAR) to match the current physician’s order. The medication label was checked, and the change was clearly noted on the medication	03/04/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHARO DALE Title: Supplier representative Date: 03/18/2026

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CREST HOME CARE	**4462 FARMCREST DRIVE, LAS VEGAS, NEVADA ,89121**

(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
	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, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph		container. The caregiver documented the updated dosage and time in the resident's record as required. A signed copy of the physician's order was requested and filed. Staff were re-educated on proper procedures for documenting and implementing medication changes. The administrator will complete routine checks to ensure all medication records remain accurate and compliant.	

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 _____	**03/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CREST HOME CARE	**4462 FARMCREST DRIVE, LAS VEGAS, NEVADA ,89121**

(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
	(b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, document review, record review and interview, the facility failed to ensure medications were administered per physician orders for 1 of 9 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 06/02/24 with diagnoses of hypertension and depression. On 03/03/26, in the afternoon, R3's medication bin contained a medication bottle labeled Metoprolol 50 milligrams (mg) one tablet by mouth once daily. A physician's order dated 11/18/25, documented Metoprolol 50 mg take one tablet daily. A Medication Verification Review Form dated 11/18/25, documented Metoprolol 50 mg take one tablet daily. R3's November 2025, December 2025, January 2026, February 2026 and March 2026 MARS documented Metoprolol 50 mg take one tablet two times a day. On 03/03/26 in the afternoon, the Caregivers and Owner indicated R3's medication bottle which read Metoprolol 50 milligrams (mg) one tablet by mouth once daily was correct. The Owner acknowledged the facility had been administering R3's medication incorrectly as prescribed by the physician's orders since the change on 11/18/25. The facility Medication Policy (undated), documented to reviews for accuracy and appropriateness, at least once every six months, the regimen of drugs taken by each resident of the facility. Section (3) verify that orders for medications had been accurately transcribed in the record of the medication administered to each resident. Severity: 2 Scope: 1			
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	0890	The caregiver immediately reviewed all physician orders and updated the Medication Administration Records (MARs) for Resident #1 and Resident #7 to include all current medications. All medications in each resident's medication bin were cross-	03/01/2026

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 _____	**03/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CREST HOME CARE	**4462 FARMCREST DRIVE, LAS VEGAS, NEVADA ,89121**

(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
	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 2 of 9 residents (Resident #1 and #7). Findings include: Resident #1 (R1) was admitted on 05/10/23 with diagnosis of hypertensive heart disease and hypothyroidism. On 03/03/26, in the afternoon, a bottle of Citalopram 40 milligram (MG) tablets take one table daily, was found in the medication bin of R1. Physicians order dated 05/10/25 documented Citalopram, 40 milligram tablet. Take one tablet by mouth once daily. Citalopram 40 mg tablets for R1 were not documented on the March 2026 MAR. Resident #7 (R7) was admitted on 05/30/24 with a diagnosis of Cardiomyopathy. On 03/03/26, in the afternoon, a bottle of Docusate SOD capsule 100 mg and a bottle of Benzonatate 200 mg capsules was found in the medication bin of R7. Physicians order dated 02/12/26 documented Docusate SOD capsule 100 mg take one by mouth once a day and Benzonatate 200 mg take 1 capsule by mouth three times a day as needed for cough. Docusate SOD and Benzonatate for R7 were not documented on the March 2026 MAR. On 03/03/26, in the afternoon, the Owner and the Caregiver confirmed they forgot to list Citalopram tablets, Docusate SOD capsules and Benzonatate capsules on R1 and R7's March 2026 MAR's. Severity: 2 Scope: 1		checked with physician orders to ensure accuracy. The missing medications were added to the March 2026 MAR and properly documented. Staff were re-educated on the requirement to ensure all prescribed medications are recorded on the MAR. The administrator will review all MARs to confirm they match physician orders and medication supplies. The administrator will continue to monitor routinely to ensure ongoing compliance and accuracy.	