Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	367	A. BUILDING _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE RESIDENTIAL CARE CORP	3158 KINGSPOINT AVENUE, LAS VEGAS, NEVADA ,89120

(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 completed at your facility on 07/10/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for ten 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 ten. Ten resident files and four employee files were reviewed. The facility received a grade of D. 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		

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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. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 10 employees had completed annual caregiver training (Employee #3). Findings include: Employee #3 (E3) E3 was hired on 01/07/24 as a Caregiver. E3's file documented E3 received one hour of annual Caregiver training on 05/19/25 and four hours of annual Caregiver training on 06/04/25. E3's file lacked documented evidence E3 completed an additional three hours of annual Caregiver training in 2025. On 07/10/25 in the morning, the Caregiver acknowledged the missing Caregiver training and reported the training was not completed. Severity: 2 Scope: 1	0065	Tag 0065 * E3 Caregiving Training completed * Make alarm or reminders for annual certificate expirations * Post alert or reminder sheet for expiration dates and renewal of certificates. * E3 will be responsible to monitor all training renewals. * Completed 7/18/2025	07/30/2025
0072 SS= E	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication,	0072	Tag 0072 * E2 Med Training presented certificates prior year 2000-2011. E2 had been in the group home program since 1990 and	07/30/2025

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	including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 4 employees received initial 16 hours (E2) and annual training (E3) of medication management training (Employee #2 and #3). Findings include: Employee #2 (E2) E2 was hired on 01/07/24, as the Administrator. E2 completed eight hours of medication management training on 02/03/25. E2's file lacked documented evidence of the initial 16 hour medication management training. On 07/10/25 in the morning, the Administrator indicated E2 had medication training prior to 2011 and did not take a 16 hour course. The Administrator was provided the opportunity to provide the missing medication management training and failed to provide the documented evidence by 12:00 PM on 07/11/25. Employee #3 (E3) E3 was hired on 01/07/24, as a Medication Technician. E3 completed 16 hours of medication management training on 12/06/23. E3's file lacked documented evidence of eight hours of annual medication management training. On 07/10/25 in the morning, E3 acknowledged the missing documentation		maintained the 8hr refresher courses throughout all these years. E3 completed the annual 8hr refresher course. * E3 will post alert and time sheet for renewal of all annual training. * E3 will ensure that the plan of correction will be implemented. * Completed 7/19/2025	

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	and reported E3 did not take the eight hour annual course. Severity: 2 Scope: 2			
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 1) an initial two-step tuberculosis (TB) was completed upon hire, 2) an annual signs and symptoms questionnaire was completed, and 3) a physical examination was completed upon hire for 1 of 4 employees (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 01/07/24, as the Administrator. E2's file revealed a negative chest x-ray completed on 10/07/13. E2's file lacked documented evidence of a two-step TB test and/or positive TB test, an annual 2025 TB test or signs and symptoms questionnaire, and a physical examination. On 07/10/25 in the morning, the Administrator was unable to provide documented evidence of the missing TB tests and physical examination. The Administrator was provided the opportunity to provide the missing documentation and failed to provide the documented evidence by 12:00 PM on 07/11/25. Severity: 2 Scope: 1	0102	Tag 0102 * E2 had positive skin test step 1 (8/2/1999) and 2 (8/9/1999). Chest x-ray was done was done on (8/12/1999) with no evidence of active disease. E2 annual tuberculosis questionnaire and Physical Exam was completed. * E3 will keep track and update the Tuberculosis Annual Questionnaire. * E3 will ensure that the binders are updated and the plan of correction will be implemented. * Completed 7/15/2025	07/30/2025
0515 SS= E	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	0515	Tag 0515 * Annual Care plans for R1,R3,R4,R5,R6,R8 and R9 were updated. * E3 will make a time sheet for updating annual care plans for each resident. * E3 will ensure that that the POC is implemented. * Completed 7/11/2025	07/30/2025

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	ensure 7 of 10 residents had an initial and/or annual person-centered service plan (Resident #1, #3, #4, #5, #6, #8, and #9). Findings include: Resident #1 (R1) R1 was admitted on 05/01/24, with diagnosis including dementia and anxiety. R1's file revealed a person-centered service plan dated 05/01/24. R1's file lacked documented evidence of an annual person-centered service plan. Resident #3 (R3) R3 was admitted on 06/30/25, with diagnosis including hyperlipidemia. R3's file lacked documented evidence of an initial person-centered service plan. Resident #4 (R4) R4 was admitted on 06/14/23, with diagnosis including diabetes. R4's file revealed a person-centered service plan dated 01/07/24. R4's file lacked documented evidence of an annual person-centered service plan. Resident #5 (R5) R5 was admitted on 06/11/25, with diagnosis including hypertension and end stage renal disease. R5's file lacked documented evidence of an initial person-centered service plan. Resident #6 (R6) R6 was admitted on 06/14/24, with diagnosis including vascular disease. R6's file revealed a person-centered service plan dated 06/14/24. R6's file lacked documented evidence of an annual person-centered service plan. Resident #8 (R8) R8 was admitted on 01/10/24, with diagnosis including dementia. R8's file lacked documented evidence of an initial and annual person-centered service plan. Resident #9 (R9) R9 was admitted on 11/26/24, with diagnosis including hemiplegia. R9's file lacked documented evidence of an initial person-centered service plan. On 07/10/25 in the morning, the Caregiver acknowledged the residents were missing the person-centered service plans. Severity: 2 Scope: 3			
0938 SS= E	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	0938	Tag 0938 * Annual ADL's for R1,R3, R4, R6, and R8 were updated. * E3 will make a time sheet to remind the annual updates of ADL's for all residents. * E3 will ensure that the POC will be implemented. * Completed 7/11/2025	07/30/2025

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	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 initial and/or an annual Activities of Daily Living (ADL) Assessment was completed for 5 of 10 residents. (Resident #1, #3, #4, #6, and #8) Findings include: Resident #1 (R1) R1 was admitted on 05/01/24, with diagnosis including dementia and anxiety. R1's file documented an initial ADL assessment dated 05/01/24. R1's file lacked documented evidence of an annual ADL Assessment. Resident #3 (R3) R3 was admitted on 06/30/25, with diagnosis including hyperlipidemia. R3's file lacked documented evidence of an initial ADL assessment. Resident #4 (R4) R4 was admitted on 06/14/23, with diagnosis including diabetes. R4's file documented an initial ADL assessment dated 01/07/24. R4's file lacked documented evidence of an annual ADL Assessment. Resident #6 (R6) R6 was admitted on 06/14/24, with diagnosis including vascular disease. R6's file documented an initial ADL assessment dated 06/14/24. R6's file lacked documented evidence of an annual ADL Assessment. Resident #8 (R8) R8 was admitted on 01/10/24, with diagnosis including dementia. R8's file lacked documented evidence of an initial and annual ADL assessment. On 07/10/25 in the morning, the Caregiver confirmed the missing ADL assessments and acknowledged they were not completed. Severity: 2 Scope: 2			

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1011 SS= F	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. Inspector Comments: Based on record review and interview, the facility failed to ensure eight hours of mental illness training was completed within 60 days of hire for 3 of 4 employees (Employee #1, #2, and #4). Findings include: Employee #1 (E1) E1 was hired on 01/01/25, as a Caregiver. E1's file revealed three hours of mental illness training was completed on 12/03/24. E1's file lacked documented evidence of an additional five hours of mental illness training. Employee #2 (E2) E2 was hired on 01/07/24, as the Administrator. E2's file lacked documented evidence of eight hours of mental illness training. Employee #4 (E4) E4 was hired on 03/01/25, as a Caregiver. E4's file lacked documented evidence of eight hours of mental illness training. On 07/10/25 in the morning, the Administrator was unable to provide documented evidence of the missing mental illness training. The Administrator was provided the opportunity to provide the missing documentation and failed to provide the documented evidence by 12:00 PM on 07/11/25. On 07/10/25 in the morning, the Caregiver acknowledged the missing documentation for E1 and E4 and was unable to provide the employees mental illness training. Severity: 2 Scope: 3	1011	Tag 1011 * E1,E2 and E4 complied the required hour of training for Mental Illness. * E3 will keep a time sheet to keep track of annual training renewal for all staff. * E3 will ensure that the POC will be implemented. * Completed 7/30/2025	07/30/2025
1540 SS= D	Cultural Competency Training - R004-24 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency	1540	Tag 1540 * E4 complied with the requirements of Cultural Competency Training. * E3 will see to it that all staff's training will be renewed and will make a time sheet to remind renewal dates for annual trainings. * E3 will ensure that the POC will be implemented.	07/30/2025

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	training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on record review and interview, the facility failed to		* Completed 7/30/2025	

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	ensure 1 of 10 employees received cultural competency training through a Bureau approved course (Employee #4). Findings include: Employee #4 (E4) E4 was hired on 03/01/25, as a Caregiver. E4's file revealed cultural competency on 04/08/25. E4's training was not taken through a Bureau approved course. On 07/10/25 in the morning, the Caregiver acknowledged the course was not taken through a Bureau approved course and was unable to provide documentation of cultural competency training for E4. Severity: 2 Scope: 1			
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current	1600	Tag 1600 * E3 made it sure that R1,R2,R3,R4,R5,R6,R7,R8 and R9's preferred pronoun and gender expression profiles are updated. R10 was discharged from the group home last 07/12/2025. * E3 will make sure that all residents will be interviewed for preferred pronoun and gender expression upon admission. * E3 will ensure that the POC will be implemented. * Completed 7/11/2025	07/30/2025

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	anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on interview and record review, the facility failed to ensure 10 of 10 resident files included documentation of preferred pronoun, gender expression and sexual orientation (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). Findings include: A review of residents files revealed Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10, lacked documentation of gender identity or expression and preferred name. On 07/10/25 in the morning, the Caregiver confirmed there was no documentation of preferred pronoun, gender expression and sexual orientation for the residents. Severity: 1 Scope: 3			

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0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure a medical exemption request was submitted for 1 of 10 residents who was bedfast to the Bureau to retain the resident (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 04/25/25, with diagnosis including obesity and anxiety. On 07/10/25 in the morning, R2 was lying in bed on their back and was unable to reposition themselves in bed. R2's file lacked documented evidence of an application for submission and/or an approved medical exemption for being bedfast. On 07/10/25 in the morning, the Caregiver acknowledged R2 did not have a medical exemption for being bedfast. The Caregiver indicated R2 was unable to turn to the side by themselves while lying in bed and was bedfast. Severity: 2 Scope: 1	0830	Tag 0830 * R2 was discharged and transferred to another facility last 07/12/2025. * E3 and Administrator will assess patients before admission and will make sure that no bed fast residents are admitted in the facility. * E3 and Administrator will monitor and ensure that the POC will be implemented * Completed 07/12/2025.	07/30/2025
0870 SS= F	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC	0870	Tag 0870 * All Resident's Medication Review was updated and signed by the Pharmacist and Administrator. R10 was discharged last 7/12/2025 * E3 will make sure that all resident's Medication Review will be updated at least every 6 months, signed by the Pharmacist and Administrator. * E3 will ensure that the POC will be implemented. * Completed : 7/10/2025	07/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	367	A. BUILDING _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE RESIDENTIAL CARE CORP	3158 KINGSPOINT AVENUE, LAS VEGAS, NEVADA ,89120

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	449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a medication review, was completed every six months, for 7 of 10 residents (Resident #1, #4, #6, #7, #8, #9 and #10). Findings include: Resident #1 (R1) R1 was admitted on 05/01/24, with diagnosis including dementia and anxiety. R1's file revealed the past two six month medication reviews were not completed. Resident #4 (R4) R4 was admitted on 06/14/23, with diagnosis including diabetes. R4's file revealed the past two six month medication reviews were not completed. Resident #6 (R6) R6 was admitted on 06/14/24, with diagnosis including vascular disease. R6's file revealed the past two six month medication reviews were not completed. Resident #7 (R7) R7 was admitted on 01/30/25, with diagnosis including hypertension. R7's file revealed a six month medication review was not completed. Resident #8 (R8) R8 was admitted on 01/10/24, with diagnosis including dementia. R8's file revealed the past two six month medication reviews were not completed. Resident #9 (R9) R9 was admitted on 11/26/24, with diagnosis including hemiplegia. R9's file revealed a six month medication review was not completed. Resident #10 (R10) R10 was admitted on 07/10/24, with diagnosis including dementia. R10's file revealed a six month medication review was not completed. On 07/10/25 in the afternoon, the Caregiver acknowledged the missing medication reviews and was unable to provide the documentation. Severity: 2 Scope: 3			

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	367	A. BUILDING _____ B. WING _____	07/10/2025

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on interview and record review, the facility failed to ensure an ultimate user agreement, authorizing the facility to administer medications to a resident, was completed for 2 of 10 residents (Resident #2 and #7). Findings include: Resident #2 (R2) R2 was admitted on 04/25/25, with diagnosis including obesity and anxiety. R2's file lacked documented evidence of a signed ultimate user agreement which stated the facility was to administer R2's medications. Resident #3 (R3) R3 was admitted on 06/30/25, with diagnosis including hyperlipidemia. R3's file lacked documented evidence of a signed ultimate user agreement which stated the facility was to administer R3's medications. On 07/10/25 in the morning, the Caregiver acknowledged the missing documentation and indicated they were having issues with getting response from the responsible party to sign the documents. Severity: 2 Scope: 1	0876	Tag 0876 * R3 Ultimate User Agreement was signed and updated. R2 was discharged last 7/12/2025 * E3 will make sure that all residents will comply the Ultimate User Agreement upon admission. * E3 will ensure that the POC will be implemented. * Completed 7/24/2025	07/30/2025

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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 received a two-step tuberculosis (TB) test and an annual TB test (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 05/01/25, with dementia and anxiety. R1's file revealed a one-step TB test on 05/01/24. R2's file lacked documented evidence of a second-step TB test and an annual 2025 TB test. On 07/10/25 in the morning, the Administrator acknowledged the missing TB test and was unable to provide the documentation. Severity: 2 Scope: 1	0936	Tag 0936 * R1 Annual TB test was done last 05/29/2025. PCP was not able to give the facility the results on time. R1 Quanteferon TB test found negative. * E3 will make alert time sheets for annual TB tests for all residents. * E3 will ensure that the POC will be implemented. * Completed 7/11/2025	07/30/2025