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 _____	**04/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	**1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure and complaint investigation survey completed at your facility on 04/02/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, Category II residents. The census at the time of the survey was nine. Ten resident files and four employee files were reviewed. The facility received a grade of D. There were three complaints investigated: Substantiated: Complaint #NV00073361 was substantiated (see Tags 0515 and 0950). Complaint #NV00073811 was substantiated (see Tags Y370 and Y430) Unsubstantiated. Complaint #NV00073768 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observations of residents appearing appropriately hydrated, fluids available at bedside, residents personnel property onsite, the fire panel and riser room in the garage, the living arrangement in the garage and facility smoke detectors. Interviews were conducted with Caregivers, the Owner, the Administrator and residents. Clinical Record Review of 10 records, which included the resident of concern. Document review of facility Admission and discharge policy, residents belongings, facility incident reports and Las Vegas Fire & Rescue inspection reports. 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: MINKYUNG LIM Title: Administrator Date: 05/27/2025

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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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 record review and interview, the facility failed to ensure 1 of 4 employees had evidence of a pre-employment physical examination and two-step tuberculosis (TB) test at the time of hire, per the requirement. (Employee #3) Employee #3 (E3) E3 was hired on 3/01/25 as a Caregiver. E3's record lacked documented evidence of a pre-employment physical examination. E3's record documented a two-step TB test with a final read date of 03/21/25, three weeks after the hire date. On 04/02/25 at 11:00 AM, E3 confirmed not having a pre-employment physical examination. E3 confirmed the TB tests were completed after they began providing care for the residents. Severity: 2 Scope: 1	0102	1) Corrective action will be taken by ensuring pre-employment physical examination and two-step tuberculosis (TB) test to be completed at the time of hire and 1 step to be completed annually (E3 had negative result for both steps). E3 received physical examination on 04/15/25 (See attachment A-1). The 2-Step TB was completed. The 1st step was given on 03/03/25, read on 03/05/25. The 2nd step was given on 03/19/25, read on 03/21/25 (See attachment A-1a). 2) The employee checklist will be used to make sure all requirements are met and the checklist will be reviewed quarterly to stay in compliance (See attachment A-2). 3) We will monitor the corrective action by using the checklist and it will be completed annually and/or when there are changes in employees' employment status. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/18/25	04/18/2025

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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 record review and interview, the facility failed to ensure 1 of 4 employees had a background check clearance through the Nevada Automated Background Check System (NABS) for this facility. (Employee #1) Findings include: Employee #1 (E1) E1 was hired on 09/09/21 as the Administrator. E1's record documented a NABS Clearance letter dated 09/17/20 and another letter dated 03/08/24, both for other facilities. E1's record lacked documented evidence of a NABS Clearance letter for this facility. On 04/02/25 at 11:15 AM, the Administrator confirmed the NABS Clearance letter for E1 was for another facility. This was a repeat deficiency from the 04/09/24 annual State Licensure survey. Severity: 2 Scope: 1	0104	1) Corrective action will be taken by ensuring all employees to have a background check clearance through the Nevada Automated Background Check System (NABS) for this facility within 10 days of hire. The inspection report stated there were 2 letters dated on 09/09/21 and on 03/08/24, both for other facilities and that it was a repeated deficiency from 2024 but the clearance letter dated 03/08/24 was for this facility (See attachment A). 2) The employee checklist will be used to make sure all requirements are met (See attachment A-2) and the checklist will be reviewed quarterly to stay in compliance. 3) The owner and the administrator will monitor the corrective action by checking the employee checklist on a regular basis and it will be completed annually and/or when there are changes to employees' employment status. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/20/25	04/20/2025
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the interior and exterior of the facility was maintained. Findings include: On 04/02/25 in the morning, during a tour of the facility observed the following: Kitchen - Observed soiled aluminum foil at the bottom of the oven. The oven door was soiled with caked on food debris. There was a 20 pound bag of open rice on the floor by the patio door in the kitchen. On 04/02/25 at 9:25 AM, the Owner confirmed the bag of rice on the floor	0178	1) The corrective action will be taken by ensuring that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. The soiled aluminum foil at the bottom of the oven has been replaced and the oven door has been cleaned (See attachment A-3). The rice that was in a 20 lbs rice bag is now in plastic a holder on the kitchen counter (See attachment A-3a). The owner contacted junk removal company to remove objects (See attachment A-3b). They came and cleaned the list of things stated in the inspection report (e.g. miscellaneous boxes and trashes bags in the backyard and along the side of the facility) (See attachment A-3c). The miscellaneous trash, fresh dog feces and the rocks have been removed (See attachment A-3d). The weeds throughout front and backyard	04/23/2025

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	was open. Yard - Observed an excessive amount of objects in the backyard and along the side of the facility, including: tables, commodes, mattresses, bed rails, metal bed box springs, bed frames, blanket, card table chairs, brooms, several boxes on the ground with miscellaneous objects in them, walker, vacuum cleaner, one four drawer and one five drawer metal file cabinet, a plastic three drawer storage unit, miscellaneous wood planks, fans, empty plastic bottles, couch cushions, miscellaneous paper empty food boxes and bottles, several boxes and white plastic bags with unidentified contents, wood door. There were sizable weeds throughout front and back yard. There was miscellaneous trash and fresh dog feces on the rocks in the backyard. Garage - Observed multiple plastic bags with unidentified contents and multiple empty cereal boxes stacked in the corner. On 04/02/25 at 9:15 AM, observed the following expired food in the refrigerator in the garage: an open jar of Tuna Spread expired 11/20/24, an open jar of pickles expired 01/21/25, an open bottle of Poppyseed Dressing expired 12/04/24 and an open bottle of Hot Giardiniera expired 09/08/22. A can of milk on the refrigerator shelf had a hole on the top of the metal can. On 04/02/25 at 9:15 AM, two Caregivers confirmed the observations of the expired food in the garage refrigerator. The garage wall had an opening/window with cardboard covering it and a round object on the lower right side of the opening on the inside and from the outside left side of window had the cardboard partially covering the left side of the window. There was no window opening. A window on the garage door had aluminum foil covering it. On 04/02/05 in the morning, a Caregiver and the Owner confirmed the observations. The Owner indicated there was someone coming to the facility to remove the items in the yard on this date, however the Owner was not able to provide evidence of an agreement for the job. Upon leaving the facility, there had		has been removed (See attachment A-3e). The unidentified objects in the garage has been cleaned (See attachment A-3f). The employees also went through all the food in the refrigerator and discarded expired food (See attachment A-3g). The window openings in the garage also have been cleaned (See attachment A-3h). 2) The owner and the administrator will monitor interior and exterior and landscaping to make sure they are well maintained. We will observe every 30 days to stay in compliance. 3) We will make sure to contact junk removal company on time in the future to make sure premises are clean and that the interior, exterior and landscaping of the facility are well maintained. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/23/25.	

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	been no removal of the yard objects. Severity: 2 Scope: 3			
0370 SS= D	Housing for staff members - NAC 449.224 Housing for staff members. (NRS 449.0302) 1. Bedrooms must be provided for any members of the staff of a residential facility and their families who live at a residential facility. The bedrooms must comply with the provisions of subsections 2 to 8, inclusive, of NAC 449.218 and the provisions of NAC 449.220 and 449.221. Inspector Comments: Based on document review, observation and interview, the facility failed to provide a bedroom for a live-in Caregiver, as required. Findings include: On 04/02/25 at 8:40 AM, observed a bed and dresser with personal belongings, separated by a folding room divider, in the southwest corner of the garage. On 04/02/25 at 8:40 AM, R4 reported they lived at the facility for about three years and slept in the bed observed in the corner of the garage. On 04/02/25 at 9:50 AM, the Owner confirmed R4 lived at the facility and slept in the bed in the garage or on the couch in the living room. The Owner confirmed there was not a designated bedroom for R4 in the home. On 04/02/25 in the morning, a Las Vegas Fire & Rescue Fire Inspector was onsite and documented the garage area was currently being utilized as a living and sleeping area for an employee. The Inspector noted the garage was not an approved use for dwelling purposes, and to cease this non-permitted use immediately. Severity: 2 Scope: 1 Complaint #NV00073811	0370	1) Corrective action will be taken by ensuring bedrooms to be provided for any members of the staff of a residential facility and their families who live at a residential care facility. E4's bedroom was immediately prepared and now the E4 stays in bedroom #1 (See attachment A-3). The attached is the floor plan of the facility indicating room numbers and where the residents are housed as well as where the live-in caregiver sleeps in (Attachment A-3a) 2) In the future, the owner and the administrator will make sure that the bedroom will be provided for any members of the staff of a residential facility and their families who live at a residential facility. 3) We will monitor the corrective action by reviewing employees/families live-in situations regularly to stay in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/18/25	04/18/2025
0430 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for	0430	1) Las Vegas Fire & Rescue Fire inspector has been coming on a routine basis to inspect the facility to ensure that the facility complies with the regulations. We always followed their order to make sure everything was in compliance. When the Las Vegas Fire & Rescue Fire inspector finds something that is not working or needs attention, he/she lets us know and comes	04/20/2025

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	residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure fire alarm monitoring, fire sprinkler and smoke detectors were functioning properly, per the requirement. Findings include: On 04/02/25 in the morning, there were smoke detectors in every room, however only the smoke detector at the fire panel was interconnected/hard wired to the fire panel, as required. The fire sprinkler riser (located in the garage) inspected on 02/07/25, documented a repeat deficiency, "2 out of date gauges, need to drain water to building to replace gauges". The gauges were more than five years old. On 04/02/25 in the morning, the Fire Central Station Monitor had not been inspected and was not in working order. On 04/02/25 in the morning, a Las Vegas Fire & Rescue Fire Inspector was onsite for this survey and confirmed continued issues with the fire alarm panel. The Inspector documented the smoke alarms on the ceiling or wall outside each sleeping area, in the immediate vicinity of the bedrooms and within each sleeping room were not interconnected to the fire panel, as required. The Inspector noted the smoke alarms were older than 10 years. The Fire Alarm Central Station Monitoring Permit had expired and should have been renewed and tested. On 04/02/25 in the morning, documentation of monthly fire drills was not available to review. On 04/02/25 in the morning, documentation of monthly smoke detector tests was not available to review. On 04/02/25 at 10:05 AM, the Owner and a Caregiver reported the staff had not conducted monthly fire		back to fix them. Since we are not experts, we always followed their order. After our inspection, the Las Vegas Fire & Rescue Fire inspector came again on the following week and did a new set of inspection and gave us the report (See attachment A-5). Another inspection was conducted by them on 04/16/25 and the following violations have been corrected: improper occupancy of the garage, new smoke alarms, multi-plug in outlet, breached wall in riser closet, electrical in riser closet. The remaining deficiencies are: interconnectivity of smoke alarms, gauges of fire sprinkler riser, fire alarm radio permit, fire alarm panel replacement permit, emergency lights in dining area. The Las Vegas Fire & Rescue Fire inspection stated that the follow-up inspection will be in 2 weeks for the remaining work. (See attachment A-5b). The owner has been speaking to the person in charge at the Las Vegas Fire & Rescue Fire asking them to come out asap for the remaining work but they stated they have been short staffed that they were not able to come right away but they did finally set up a date for the re-inspection to finish the rest of the deficiencies. They assured us everything is being monitored (See attachment A-5c) and also stated we are scheduled on the May 15th between 10-10:30am (See attachment A-5d). We will submit this re-inspection report as soon as it is complete. The re-inspection was done on the 05/15 and on 05/16 and the facility received the pass report (See attachment A5). The attached is the tag of the fire riser sprinkler (See attachment A5A). For the monthly fire drill, it will be conducted every month on time in the future, as required by regulation. The monthly fire drill for April was conducted on 04/03/25 (See attachment A-5a) and the next drill will be conducted on the first week of May 2025. 2) The owner and the administrator will monitor more closely to the fire inspection reports to make sure they are all in	

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	drills or smoke detector tests. On 04/02/25 in the morning, the Owner acknowledged the repeated deficiencies with the fire sprinkler riser, the fire alarm monitoring system and the report from the Fire Inspector on site at the time of survey. This was a repeat deficiency from the 04/09/24 annual State Licensure survey. Severity: 2 Scope: 3 Complaint #NV00073811		compliance and remind the company to fix things as soon as they can. We will also monitor fire drill reports every month to make sure they are completed on time. 3) We will review and monitor fire inspection report and the fire drill more strictly every 30 days to stay in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/20/25	
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 record review and interview, the facility failed to ensure 1 of 4 employees acquired first aid and/or cardiopulmonary resuscitation (CPR) training within 30 days of hire. (Employee #3) Findings include: Employee #3 (E3) E3 was hired on 3/01/25 as a Caregiver. E3's record lacked documented evidence of initial first aid and CPR training. On 04/02/25 at 10:55 AM, E3 confirmed the missing first aid and CPR training and indicated E3 would be signing up for the training soon. Severity: 2 Scope: 1	0450	1) Corrective action will be taken by ensuring initial cardiopulmonary resuscitation (CPR) training is completed upon hire and renewed every 2 years for all employees. The employee #3 attended CPR class and received the certificate on 04/18/25 (See attachment A-6). 2) The employee checklist will be reviewed more thoroughly to make sure all requirements are met and the employee checklist will be reviewed quarterly to stay in compliance. 3) We will monitor the corrective action by using the employee checklist and it will be completed annually. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/20/25	04/20/2025
0515 SS= F	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,	0515	1) The person-centered service plan for all residents will be filled out during admission and reviewed at least once each year. We immediately contacted hospice providers and requested for their plan of care for residents who never received them. We also recreated admission form that includes gender identity and sexual orientation. We	04/22/2025

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	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 interview and record review, the facility failed to develop a person-centered service plan for 9 of 10 residents (Resident #1, #2, #3, #4, #5, #6, #7, #8 and #9). Findings include: Resident #1 (R1) R1 was admitted on 03/06/25 with diagnosis including type 2 diabetes mellitus. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted on 07/31/24 with heart failure and cerebral infarction. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted on 03/01/25 with diagnosis including chronic obstructive pulmonary disorder and Parkinson's disease. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted on 12/06/24 with diagnosis including type 2 diabetes mellitus and dyslipidemia. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted on 11/01/24 with diagnosis including traumatic brain injury. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted on 11/15/24 with diagnosis including Alzheimer's disease and psychosis. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted on 06/21/24 with diagnosis including senile degeneration of the brain. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted on 03/02/24 with diagnosis including Parkinson's disease. R8's file lacked a person-centered service plan. Resident #9 (R9) R9 was admitted on 06/10/21 with diagnosis including hypertension. R9's file lacked a person-centered service plan. On 02/21/24 in the afternoon, the Owner confirmed person-centered service plans were not developed		then created person-centered service plan. R1 was admitted with diagnosis including type II DM (See attachment A-7). R2 was admitted with diagnosis including with heart failure and cerebral infarction (See attachment A-7a). R3 was admitted with diagnosis including COPD and Parkinson's disease (See attachment A-7b). R4 was admitted with diagnosis including type II DM and dyslipidemia (See attachment A-7c). R5 was admitted with diagnosis including traumatic brain injury (See attachment A-7d). R6 was admitted with diagnosis including Alzheimer's disease and psychosis (See attachment A-7e). R7 was admitted with diagnosis including senile degeneration of the brain (See attachment A-7f). R8 was admitted with diagnosis including Parkinson's disease (See attachment A-7g). R9 was admitted with diagnosis including hypertension (See attachment (A-7h). 2) The owner and the administrator will monitor person-centered service plan to make sure they are obtained during admission and reviewed annually. 3) We will review and monitor residents' and hospice folders more strictly every 30 days to stay in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/22/25	

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	for R1, R2, R3, R4, R5, R6, R7 R8 and R9. Severity: 2 Scope: 3 Complaint #NV00073361			
0690 SS= F	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the failed to ensure oxygen tanks were secured. Findings include: On 04/02/25 at 9:20 AM, observed three small	0690	1) Corrective action will be taken by ensuring oxygen tanks to be secured. The oxygen tanks that were in room #5 were for a former resident who already has been discharged from the facility. So we asked them to be removed and it is no longer in room #5 (See attachment A-8). 2) The owner and the administrator will make sure all oxygen tanks are secured to make sure to stay in compliance. 3) We will monitor oxygen tanks every 30 days to make sure they are secured. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/20/25	04/20/2025

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		A. BUILDING _____ B. WING _____	**04/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J GROUP HOMECARE	**1604 WILDWOOD DRIVE, LAS VEGAS, NEVADA ,89108**

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	oxygen tanks sitting on the floor in the closet in Room #5 unsecured. On 04/02/25 at 9:50 AM, the Owner confirmed the observation, explaining the oxygen tanks were for a former resident who was discharged in August 2024 and acknowledged the tanks should have been secured. This was a repeat deficiency from the 04/09/24 annual State Licensure survey. Severity: 2 Scope: 3			

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0870 SS= D	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 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 six month medication reviews were signed off and reviewed, by the Administrator, for 1 of 10 residents (Resident #9) Findings include: Resident #9 (R9) was admitted on 06/10/21 with diagnosis including hypertension. Medication reviews for R9 dated 09/12/24 and 01/16/25 were not reviewed or signed off by the Administrator. On 04/02/25 in the morning, the Administrator had not reviewed or signed off on six month medication reviews for R9. Severity: 2 Scope: 1	0870	1) The medication reviews for all residents will be signed by the administrator on time in the future, as required by regulation. The administrator reviewed R9's medication reviews on 09/12/24 and on 01/16/25 and signed them (See attachment A-9). 2) The owner and the administrator will monitor medication reviews more closely to make sure all are reviewed and signed by the administrator on time. 3) We will review and monitor medication reviews more strictly every 30 days to stay in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/19/25	04/19/2025

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0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured. Findings include: On 04/02/25 at 9:30 AM a box containing medications in the refrigerator in the garage, was unlocked. The box contained Morphine, Lorazepam, Bisacodyl and Milk of Magnesia. On 04/02/25 at 9:30 AM, the Owner confirmed the box containing the medications was not locked, and acknowledged it should have been. Severity: 2 Scope: 1	0920	1) The corrective action will be taken to make sure medications including OTC medications to be stored in a locked area that is cool and dry. The owner immediately checked the medication box and locked it (See attachment A-i). 2) We will make sure the medication box in the refrigerator and the cabinet with medication boxes are locked at all times. 3) The owner and the administrator will train employees again to make sure medication boxes and cabinet is locked at all times and will monitor everyday to stay in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/20/24	04/20/2025
0950 SS= D	Hospice Care Responsibilities of Staff - NAC 449.275 Residential facility which provides residents with hospice care: Responsibilities of staff; retention of resident with special medical needs. (NRS 449.0302) 1. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to	0950	1) We immediately contacted all hospice providers for residents who are on hospice to send us copies of their care plan. We've asked hospice staff previously to leave their folders which includes care plan at the facility and to update their folders routinely so we will remind them again to give us reports on time. R1 was admitted with diagnosis including type II DM (See	04/22/2025

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	NAC 449.0186 for that resident. Inspector Comments: Based on interview and record review, the facility failed to obtain a hospice care plan, for 6 of 10 residents (Resident #1, Resident #3, Resident #5, Resident #6, Resident #7 and Resident #8). Findings include: Resident #1 (R1) R1 was admitted on 03/06/25 with diagnosis including type 2 diabetes mellitus. Review of R1's medical record revealed R1 was currently on hospice and there was no hospice care plan available for review. Resident #3 (R3) R3 was admitted on 03/01/25 with diagnosis including chronic obstructive pulmonary disorder and Parkinson's disease. Review of R3's medical record revealed R3 was currently on hospice and there was no hospice care plan or hospice records available for review. Resident #5 (R5) R5 was admitted on 11/01/24 with diagnosis including traumatic brain injury. Review of R5's medical record revealed R5 was currently on hospice and there was no hospice care plan available for review. Resident #6 (R6) R6 was admitted on 11/15/24 with diagnosis including Alzheimer's disease and psychosis. Review of R6's medical record revealed R6 was currently on hospice and there was no hospice care plan available for review. Resident #7 (R7) R7 was admitted on 06/21/24 with diagnosis including senile degeneration of the brain. Review of R7's medical record revealed R7 was currently on hospice and there was no hospice care plan available for review. Resident #8 (R8) R8 was admitted on 03/02/24 with diagnosis including Parkinson's disease. Review of R8's medical record revealed R8 was currently on hospice and there was no hospice care plan available for review. On 04/02/25, in the morning, a Caregiver indicated they had not seen any care plan's for R1, R3, R5, R6, R7 or R8. On 04/02/25, in the morning, the Owner confirmed the facility had not obtained hospice care plan's for R1, R3, R5, R6, R7 or R8. Severity: 2		attachment A-j). R3 was admitted with diagnosis including COPD and Parkinson's disease (See attachment A-j1). R5 was admitted with diagnosis including traumatic brain injury (See attachment A-j2). R6 was admitted with diagnosis including Alzheimer's disease and psychosis (See attachment A-j3). R7 was admitted with diagnosis including senile degeneration of the brain (See attachment A-j4). R8 was admitted with diagnosis including Parkinson's disease (See attachmentA-j5). 2) The owner and the administrator will monitor hospice care plan on a regular basis to make sure they are obtained and kept at the facility. 3) We will review and monitor residents' and hospice folders more strictly every 30 days to stay in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/22/25	

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	Scope: 3 Complaint #NV00073361			
1600 SS= F	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 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	1600	1) The corrective action will be taken by ensuring that a resident is addressed by his or her preferred pronoun and in accordance with his or her gender identity or expression. We created a new admission form that includes these information. We will use this form in the future to comply with the regulation. R1's new admission form has been completed (See attachment k). R2's new admission form has been completed (See attachment k-1). R3's new admission form has been completed (See attachment k-2). R4's new admission form has been completed (See attachment k-3). R5's new admission form has been completed (See attachment k-4). R6's new admission form has been completed (See attachment k-5). R7's new admission form has been completed (See attachment k-6). R8's new admission form has been completed (See attachment k-7). R9's new admission form has been completed (See attachment k-8). 2) The owner and the administrator will review all residents' folders including the admission form to make sure all are updated, accurately recorded and documented. 3) The owner and the administrator will review residents' folders every 30 days to make sure all are accurate and in compliance. 4) The owner and the administrator will be responsible for monitoring this corrective action. 5) 04/22/25	04/22/2025

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	or constructed in the patient or resident. Inspector Comments: Based on interview and record review, the facility failed to ensure 10 of 10 residents files included documentation of preferred pronoun, gender expression and sexual orientation. Findings include: Review of 10 of 10 resident files revealed the facility did not document, residents preferred pronoun, gender expression and sexual orientation. On 04/02/25 in the morning, the Owner confirmed they did not ask and document preferred pronoun, gender expression and sexual orientation for 10 of 10 residents, and had not added this information to their admission documents. Severity: 2 Scope: 3			