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
	4504	A. BUILDING _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT CARE GROUP HOME 2	3238 JAMESTOWN COURT, SPARKS, NEVADA ,89431

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 08/26/2024. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for seven Residential Facility for Group beds for elderly or disabled persons, and/or persons with mental illness, Category II residents. The census at the time of the survey was seven. Seven resident files were reviewed, and five employee files were reviewed. The facility received a grade of D. 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. 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 deficiencies were identified.	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: FREDA CASTRO Title: Administrator Date: 10/24/2024

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0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review and interview, the facility failed to maintain an accurate staffing schedule, including times when shifts started and ended, the type of staff working, and the day of the month the staff were working. Findings include: On 08/26/2024, review of the August 2024 staffing schedule revealed two staff members working each day Monday through Sunday. There were no work hours on the schedule to reflect which staff was working when, there was no designation of type of staff working, and no identification on the days of the month the staff were working. On 08/26/2024 at 9:10 AM, the Caregiver confirmed the work times and type of staff working was not noted on the schedule, and the scheduled lacked the days of the month the staff were working. Severity: 1 Scope: 3	0088	Tag 0088 NAC 449.199 Staffing requirement. The administrator of the facility shall maintain monthly a written schedule that includes the number and type of members of the staff assign each shift. The schedule must be amended if any changes are made. The Facility administrator had acknowledged the cited deficiency related to failure of facility administrator to post accurate staffing scheduled to the facility related lack of oversight in schedule creation. The facility administrator had missed to update the current schedule staffing on that month. The Administrator will review, and update scheduling process by implementing a reporting system to track schedule accuracy and address any issue promptly, to ensure consistent adherence to the establish staffing plan. The Administrator will review and update scheduling process to ensure guidelines for staff allocation based on monthly plan. The Administrator will designate scheduler oversight to ensure responsible for reviewing and verifying all schedule against the monthly staffing plan before finalization. The designee assistant will ensure to assist the administrator and bring up any issues with posted schedule if it is not updated or not posted. The Administrator of the facility will review the staff schedules regularly to identify discrepancies and address them promptly. The Administrator will ensure updated schedule staff, with work time, on the days of the month is current monthly and past schedule is retained for 6 months. The Administrator had made a schedule for one month, please see attachment Tag 0088.	10/03/2024
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	0515	Tag 0515 Supervision and treatment of residents- NAC449.259 and R043-22 Supervision and treatment of residents generally, that	10/03/2024

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	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 interview and clinical record review, the facility failed to develop a person-centered service plan for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6, and #7). Findings include: The following residents lacked a person-centered service plan during the clinical record review: - Resident #1 was admitted to the facility on 01/05/2023, with diagnoses including dementia, unspecified, type II diabetes mellitus, anxiety, and essential hypertension. - Resident #2 was admitted to the facility on 07/31/2024, with diagnoses including gait disorder, debility, edema, hypertension, and history of personal falls. - Resident #3 was admitted to the facility on 10/09/2019, with diagnoses including senile degeneration of brain, stage 3b chronic kidney disease, and progressive vascular leukoencephalopathy. - Resident #4 was admitted to the facility on 08/01/2019, with diagnoses including type II diabetes mellitus, major neurocognitive disorder, schizoaffective disorder, and adult failure to thrive. - Resident #5 was admitted to the facility on 05/02/2024, with diagnoses including mild dementia, peripheral artery disease, and peripheral vascular disease. - Resident #6 was admitted to the facility on 11/08/2023, with diagnoses including white coat syndrome with hypertension, chronic constipation, and drug induced peripheral neuropathy. - Resident #7 was admitted to the facility on 09/13/2022, with diagnoses including hemiparesis left side, dysphagia, hypertension, stroke and vascular dementia. On 08/26/2024 at 11:14 AM, the Assistant Administrator confirmed person-centered service plans were not developed for Resident #1, #2, #3, #4, #5, #6, and #7 and verbalized the Assistant Administrator was not aware of the regulation. Severity: 2 Scope: 3		resident facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other person who provides care for the resident including without limitation, a qualified provider of health care. To develop centered service plan for each resident and review each year. The Administrator of the facility had not done or developed a person-centered service plan in the past since it was not require and I was not formally informed that each resident needs a person-centered service plan of each resident who lives in a group home. The Administrator will start to develop and implement person-centered service plan for each resident that lives in the group home and review the service centered plan each month throughout the year. The administrator will start service plan immediately to all old and new admission and will start the process of patient centered care plan for the other facilities. Please see attachment for person - centered service plan of resident 1,2,3,4,5,6, 7. Please see attachment.	

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0859 SS= D	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 clinical record review, document review and interview, the facility failed to ensure an initial general physical examination with a review of systems was completed timely for 1 of 7 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 05/02/2024, with diagnoses including mild dementia, peripheral artery disease, and peripheral vascular disease. Resident #5's clinical record documented a physical exam completed on 05/21/2024, 19 days after the resident's admission. On 08/26/2024 at 11:26 AM, the Assistant Administrator confirmed Resident #5's initial physical exam was not completed on or before the resident's admission. Severity: 2 Scope: 1	0859	TAG 0859 Medical care 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. Before admission and each year after admission or more frequently if there is significant change in the physical condition of a resident. The facility shall obtain the results of gen physical examination of the resident by a qualified provider of health care. The resident # 5 was admitted to the facility on 05/2/24 with dx of mild dementia, Peripheral vascular disease and peripheral arterial diseases. Resident #5 clinical record documented Physical examination completed 5/21/24 and 19 days after resident admission to the care home. The resident #5 was not seen by a doctor before admission related to, he was living in the street and been homeless. The Washoe County social workers were informed of the requirements and the need of history and physical and latest assessments before he can move to the group home but related to difficulty finding and reaching out on him, he failed to show up on his checkup and Physical assessment was not obtained and not successful. I met him at the center and i assessed him and i was heartbroken to see him with only one leg, Left AKA and living in the street and skin rashes. Due to his being homeless and it is difficult to be contacted by the Washoe County social worker. He was requested to be placed since he had right aka. I reiterated to the social worker to see a doctor prior to admission but he missed his appointment. Established with home base provider but due to lost Medicare and Medicaid ID the administrator can't not submit all the necessary information for billing to arrange for a sooner schedule time. The administrator had requested the GSC (Geriatric Specialty Care) for a sooner appointment but can't squeeze his appointment to a sooner date after helping and submitting his new patient	10/03/2024

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			packets to GSC. The Administrator will ensure that this will not happen again," failure to ensure that a patient was seen by a doctor before admission". The Administrator will ensure the patient is seen by a doctor immediately for physical exam by a professional doctor or NP before acceptance admission to the group home facility. The administrator will update policy revision to update the admission policy to require mandatory doctor's visit before any new admission and staff training on the updated policy and the importance of adhering to it. The administrator will implement a system to verify and document that a doctor's visit has occurred before admission of a new resident in the facility. Please see Physical Examination Attachment of Resident N0. 5 Tag 0859	
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	0870	Tag 0870 Medication Administration accuracy and report NAC 449.2742 Administration of Medication, responsibilities of Administrator, caregiver and employees of the facility. The administrator of the facility that provides assistance to residents in the administration of medication shall 1) ensure that physician, pharmacist, or registered nurse who does not have financial interest in the facility, including without limitation, any over the counter medication and dietary supplements taken by a resident and provides a written report of that review. TAG 0870 The Administrator had failed to ensure six months pharmacy profile review for Resident No # 4. Resident #4 lacked pharmacy review signed by reviewer for 2024. The Administrator has oversight and had missed to complete the review process and got sidetrack. The Administrator will ensure that the	10/03/2024

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	paragraph (a). Inspector Comments: Based on interview and clinical record review, the Administrator failed to ensure a six month pharmacy profile review (pharmacy review) was conducted for 2 of 7 residents in the facility longer than six months (Residents #4 and #7). Findings include: Resident #4 Resident #4 was admitted to the facility on 08/01/2019, with diagnoses including type II diabetes mellitus, major neurocognitive disorder, schizoaffective disorder, and adult failure to thrive. Resident #4's clinical record lacked a pharmacy review signed by a reviewer for 2024. Resident #7 Resident #7 was admitted to the facility on 09/13/2022, with diagnoses including hemiparesis left side, dysphagia, hypertension, stroke and vascular dementia. Resident #7's clinical record documented a pharmacy review dated 01/24/2023 and 02/27/2024. Resident #7's clinical record lacked a second pharmacy review in 2023. On 08/26/2024 at 11:00 AM, the Assistant Administrant confirmed the Resident #4's clinical record lacked six month pharmacy review in 2024 and Resident #7's clinical record lacked documentation of a second pharmacy review in 2023. Severity: 2 Scope: 1		medication review will be signed on a timely manner once medication review was handed over by visiting RN. Educated all caregivers to call the Administrator when new medication review is delivered at home by the visiting RN of home hospice RN. Please see attachment Tag 0870 The Administrator will review and to ensure the required documents are signed on time by the administrator. The Administrator will conduct training session for all staff involved in compliance to emphasized importance of timely review of medication review, The Administrator will establish and implement clear communication between caregivers and should be establish to ensure everyone is aware of the responsibilities that it need to communicate with Administrator if new medication review had arrive to the facility in order for administrator to review the medication review of resident and sign on time. Please see attachment tag 0870 A. Resident #4 Medication profile. TAG 0870 Resident #7 clinical record lacked a second pharmacy review in 2023,r/t the reported clinic provider will not help out , does not want to fill up the form and the latest medication review was on 2/27/24. The Administrator had established a good communication between the family of the resident in regards when the patient sees her primary MD so medication review will be prepared for the patient to the MD during doctor visit so medication review will be filled up by her primary MD. The Administrator will implement good communication to the family and frequent reminder about HCQC medication review every 6 months by MD, NP OR Pharmacist so medication review will be fulfilled by her MD or her pharmacist. Please see Attachment Tag 0870 B (medication review of Resident #7 performed last 09/05/24.) On 09/05/24 The resident was taken to her primary MD by her family and new medication review was brought back after	

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			seen by her primary MD.	
0874 SS= D	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on clinical record review, document review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, was reviewed and initialed by the Administrator within 72 hours for 1 of 7 residents residing in the facility for longer than six months (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 10/09/2019, with diagnoses including senile degeneration of brain, stage 3b chronic kidney disease, and progressive vascular leukoencephalopathy. Resident #3's medication profile review dated 01/29/2024, lacked the Administrator's review and initials. On 08/26/2024 at 11:48 AM, the Assistant Administrator confirmed Resident #3's medication profile review dated 01/29/2024 lacked the Administrator's initials, indicating the Administrator's review within 72 hours of receiving the report. Severity: 2 Scope: 1	0874	TAG 0874 Medication Administration-Report Received-NAC 449.2742 and RO43-22 Administration of Medication, responsibilities of administrator, caregiver and other employees of the facility. With in 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advance practice registered Nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. The Administrator failed to ensure a medication profile review performed by Physician, pharmacist, or Registered RN at least once every 6 months. The administrator failed to ensure the medication profile was checked on time by the doctor resulting a missed medication review of resident #3. The medication review was reviewed immediately upon discovery of the oversight and requested the attending MD and pharmacist to update the medication profile of the resident. The administrator will outline the long-term changes to prevent recurrence that includes adding private notebook log for the administrator to use and carry at all times to update the due dates of patient data, information and medication review profile needs so it will not be missed. The administrator had instructed the caregivers about establishing a double check system where another staff member verifies the medication profiles are reviewed on schedule to prevent oversight of due dates. The Administrator had provided additional training for the staff on the importance of timely importance medication review.	10/03/2024

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			Please see attachment Tag 0874, Resident #3 latest medication review. Tag 0874 The resident#3 medication profile dated 01/29/24, lacked the administrator's review and initial. The 4 pages medication review was checked, and the last 2 pages was not signed by the administrator thinking it was a redundancy order that it was being repeatedly rewritten four times. The administrator and reviewed immediately had reviewed the order and it were signed. The administrator had instructed the caregivers to notify the administrator when new medication review is delivered to the facility so administrator can review and sign the order. The administrator had established communication protocols if new medication review is handed over to notify the administrator ASAP. Please see attachment TAG 0874 resident #3	
1240 SS= C	Patient's Rights - Patient to be informed - NRS 449A.118 Patient to be informed of rights upon admission to facility; required disclosures and notices. [Effective January 1, 2020.] 1. Every medical facility and facility for the dependent shall inform each patient or the patient's legal representative, upon the admission of the patient to the facility, of the patient's rights as listed in NRS 449A.100 and 449A.106 to 449A.115, inclusive. 2. In addition to the requirements of subsection 1, if a person with a disability is a patient at a facility, as that term is defined in NRS 449A.218, the facility shall inform the patient of his or her rights pursuant to NRS 449A.200 to 449A.263, inclusive. 3. In addition to the requirements of subsections 1 and 2, every hospital shall, upon the admission of a patient to the hospital, provide to the patient or the patient's legal representative: (a) Notice of the right of the patient to: (1) Designate a caregiver pursuant to NRS 449A.300 to 449A.330, inclusive; and (2) Express	1240	TAG 1240 -Patient to be informed NRS 449A.118. Patients have to be informed of rights upon admission to the facility, requires disclosures and notices. The facility failed to ensure resident were informed of resident's rights upon admission. The facility admission packet lacked documented evidence of the resident being informed of resident's rights upon admission. During the past survey, no one had informed the administrator about the need of each resident rights to be a part of admission and policy packet. The Administrator of the facility had revised the admission procedures. The administrator had updated the admission process to ensure that all residents receive comprehensive information about their rights and facility policies upon admission.	10/03/2024

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	complaints and grievances as described in paragraphs (b) to (f), inclusive; (b) The name and contact information for persons to whom such complaints and grievances may be expressed, including, without limitation, a patient representative or hospital social worker; (c) Instructions for filing a complaint with the Division; (d) The name and contact information of any entity responsible for accrediting the hospital; (e) A written disclosure approved by the Director of the Department of Health and Human Services, which written disclosure must set forth: (1) Notice of the existence of the Bureau for Hospital Patients created pursuant to NRS 232.462; (2) The address and telephone number of the Bureau; and (3) An explanation of the services provided by the Bureau, including, without limitation, the services for dispute resolution described in subsection 3 of NRS 232.462; and (f) Contact information for any other state or local entity that investigates complaints concerning the abuse or neglect of patients. 4. In addition to the requirements of subsections 1, 2 and 3, every hospital shall, upon the discharge of a patient from the hospital, provide to the patient or the patient's legal representative a written disclosure approved by the Director, which written disclosure must set forth: (a) If the hospital is a major hospital: (1) Notice of the reduction or discount available pursuant to NRS 439B.260, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount under that section; and (2) Notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, which policies and procedures are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260. The notice required by this subparagraph must describe the criteria a patient must satisfy to qualify for the additional reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment. (b) If the hospital is not a major hospital, notice of any policies and procedures the hospital may		The administrator had given a training for all staff on the updated addendum admission procedures and the importance of informing residents of their rights and respecting them. The administrator of the facility had informed each resident immediately for Residents rights and each resident had signed the addendum admission policies of acknowledgement forms. The administrator will update all the other resident records in the other facility to demonstrate compliance and corrective actions been implemented. Please see attachment TAG 1240, Addendum admission policies signed by resident and resident guardian with resident rights was added to the admission agreement and policies. 1.2.3.4.5.6.7	

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	have adopted to reduce charges for services provided to persons or to provide discounted services to persons. The notice required by this paragraph must describe the criteria a patient must satisfy to qualify for the reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment. As used in this subsection, "major hospital" has the meaning ascribed to it in NRS 439B.115. 5. In addition to the requirements of subsections 1 to 4, inclusive, every hospital shall post in a conspicuous place in each public waiting room in the hospital a legible sign or notice in 14-point type or larger, which sign or notice must: (a) Provide a brief description of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, including, without limitation: (1) Instructions for receiving additional information regarding such policies and procedures; and (2) Instructions for arranging to make payment; (b) Be written in language that is easy to understand; and (c) Be written in English and Spanish. (Added to NRS by 1983, 822; A 1985, 1749; 1999, 1053, 3252; 2003, 1880; 2005, 947; 2011, 362, 697; 2019, 537, effective January 1, 2020) Inspector Comments: Based on interview and clincal record review, the facility failed to ensure residents were informed of resident's rights upon admission for 7 of 7 residents. Findings include: On 08/26/2024, during the morning, a review of the residents' clinical record and facility's admission packet lacked documented evidence of the residents being informed of resident's rights. The following residents lacked documented evidence of being informed of resident's rights upon admission: - Resident #1 was admitted to the facility on 01/05/2023, with diagnoses including dementia, unspecified, type II diabetes mellitus, anxiety, and essential hypertension. - Resident #2 was admitted to the facility on 07/31/2024, with diagnoses including gait disorder, debility, edema,			

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	hypertension, and history of personal falls. - Resident #3 was admitted to the facility on 10/09/2019, with diagnoses including senile degeneration of brain, stage 3b chronic kidney disease, and progressive vascular leukoencephalopathy. - Resident #4 was admitted to the facility on 08/01/2019, with diagnoses including type II diabetes mellitus, major neurocognitive disorder, schizoaffective disorder, and adult failure to thrive. - Resident #5 was admitted to the facility on 05/02/2024, with diagnoses including mild dementia, peripheral artery disease, and peripheral vascular disease. - Resident #6 was admitted to the facility on 11/08/2023, with diagnoses including white coat syndrome with hypertension, chronic constipation, and drug induced peripheral neuropathy. - Resident #7 was admitted to the facility on 09/13/2022, with diagnoses including hemiparesis left side, dysphagia, hypertension, stroke and vascular dementia. On 08/26/2024 at 11:50 AM, the Assistant Administrator confirmed the facility's admission intake process and resident documents did not include informing residents or their legal respresentative upon admission about resident's rights. Severity: 1 Scope: 3			
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by	1300	Tag 1300 Discrimination prohibited-NRS 449.101 Discrimination prohibited, development of anti-discrimination policy, posting of nondiscrimination statement and certain other information. The Administrator of the facility will ensure residents know where to call if he/she is discriminated in the facility. The Administrator of the facility had a nondiscrimination poster posted but no contact information for filling a complaint to the division. The Administrator of the facility had replaced and hang a new Nondiscrimination statement with contact information of division in the bottom, so resident will know how to reach out if they felt like they were discriminated in the facility.	10/03/2024

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	regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations.		Please see attachment TAG 1300(nondiscrimination poster)	

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	Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure a non-discrimination statement with the Division's contact information for filing a complaint was posted. Findings include: On 08/26/2024, observation throughout the facility revealed the required posted non-discrimination statement did not provide information of how to contact the Division to file a complaint of discrimination. On 08/26/2024, at 11:14 AM, the Assistant Administrator confirmed the non-discrimination statement posted in the facility lacked the required information on how to contact the Division to file a complaint of discrimination. Severity: 1 Scope: 3			
1600 SS= C	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 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) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must 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	1600	Tag 1600 Preferred Name/ pronoun P&P-preferred name / pronoun R016-20 sec 191.A facility shall develop policies to ensure the patient or resident is addressed by his or her gender identity or expression and (b)Adapt electronic records and any paper records the facility had to reflect the gender identity or expression of the resident. The administrator of the facility failure of lacked policies developed and resident records in compliance with Legislative Counsel Bureau File Number R016-20 Section 19 regarding resident records to reflect resident records to reflect a resident's preferred name, pronoun gender identity or expression and sexual orientation. The administrator was not informed of all the new requirement about gender orientation to include in the facility policies and documentation except from this survey. Please see attachment 1600 of updated resident's facesheet and added to Pleasant Care Group Home and policies as part of new Admission policy. The administrator had updated the facility current policies, update resident records to reflect their preferred name, pronoun, gender identity or sexual orientation to be in compliance with Ro16-20 section 19.	10/03/2024

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	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 or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure there were policies developed and resident records in compliance with Legislative Counsel Bureau File Number R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 8 of 8 residents (Residents #1, #2, #3, #4, #5, #6, and #7). Findings include: On 08/19/2024, in the morning, the eight sampled resident clinical records reviewed, Residents #1, #2, #3, #4, #5, #6, and #7		The Administrator will provide training for all staff on the updated policies and the importance of respecting resident's gender identities and expressions. The Administrator of the facility will immediately implement these new policies and update all resident about resident gender identity. All caregiver had all the training with the new facesheet and new added policy.	

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	lacked documentation to be in compliance with R016-20 Section 19. - Resident #1 was admitted to the facility on 01/05/2023, with diagnoses including dementia, unspecified, type II diabetes mellitus, anxiety, and essential hypertension. - Resident #2 was admitted to the facility on 07/31/2024, with diagnoses including gait disorder, debility, edema, hypertension, and history of personal falls. - Resident #3 was admitted to the facility on 10/09/2019, with diagnoses including senile degeneration of brain, stage 3b chronic kidney disease, and progressive vascular leukoencephalopathy. - Resident #4 was admitted to the facility on 08/01/2019, with diagnoses including type II diabetes mellitus, major neurocognitive disorder, schizoaffective disorder, and adult failure to thrive. - Resident #5 was admitted to the facility on 05/02/2024, with diagnoses including mild dementia, peripheral artery disease, and peripheral vascular disease. - Resident #6 was admitted to the facility on 11/08/2023, with diagnoses including white coat syndrome with hypertension, chronic constipation, and drug induced peripheral neuropathy. - Resident #7 was admitted to the facility on 09/13/2022, with diagnoses including hemiparesis left side, dysphagia, hypertension, stroke and vascular dementia. On 08/26/2024 at 11:14 AM, the Assistant Administrator confirmed there were no changes to residents' clinical records in compliance with the regulation. Severity: 1 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the	1700	TAG 1700 Annual Assessment of History of each Resident- NRS449.1845 Administrator of resident facility for groups to conduct annual assessment of history of each annual assessment of each resident and cause provider of health care to conduct certain examination and assessments: placement based on assessment. The administrator of a residential facility for groups shall annually cause a qualified provider of healthcare to conduct an assessment of the history of each resident in the facility Resident #5 was admitted to the facility on 5/2/24 with dx including mild dementia, PAD	10/03/2024

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	immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the facility failed to obtain a timely initial Standard Physician Assessment and Placement Determinations for 1 of 7 residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 05/02/2024, with diagnoses including mild dementia, peripheral artery disease, and peripheral vascular disease. Resident #5's clinical record documented a Standard Placement Determination dated 05/21/2024, 19 days after admission. On 08/26/2024 at 11:26 AM, the Assistant Administrator		and PVD. Resident #5 clinical record documented a Standard placement Determination dated 5/21/24,19 days after admission to the facility. The administrator had failure to conduct placement determination before admitting the resident to the facility r/t his homelessness and administrator wants to help to be place in a better environment r/t his BKA and excoriated peri rash where home health nurse come to take care of him. The Administrator will ensure that all residents being admitted to the group home should have placement determination prior to admission. The administrator will ensure that this determination is documented and reviewed by appropriate personnel. The Administrator will ensure placement determination is completely filled by professional personnel before acceptance to the group home. The administrator will ensure no acceptance and admission to the facility if Placement Determination is not complete. The administrator had instructed about the need for placement determination for every new admission to the facility.	

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	confirmed Resident #5's Standard Physician Assessment and Placement Determination should have been completed before or upon admission. Severity: 2 Scope: 1			
1825 SS= F	I C Program Responsible Person and Designee - IC Program Responsible Person and Designee LCB File No. R048-22 Sec. 5 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. Inspector Comments: Based on interview and document review, the facility failed to ensure a primary and secondary person responsible for the facility's infection control program were identified with the potential to affect 7 of 7 residents. Findings include: On 08/26/2024 at 2:00 PM, the facility lacked documented evidence to identify a primary and secondary person responsible for the facility's infection control program. On 08/26/2024 at 2:23 PM, the Assistant Administrator verbalized the facility had not designated a primary and secondary person responsible for the facility's infection control program. Severity: 2 Scope: 3	1825	TAG 1825 IC Program Responsible Person and Designee. - IC program Responsible Person and Designee LCB File No. R048-22 sec 5. The program to prevent and control infection within the facility for the dependent developed pursuant to paragraph a) must provide designation who is responsible for infection control and b) A secondary person who is responsible for infection control at all times. The interview and documentation review the facility failed to ensure a primary and secondary person responsible for the facility's infection control program. The administrator of the facility lacked documented evidence to identify a primary and secondary person responsible for the facilities infection control. The Administrator had trained staff last year, but the rest of the staff were given lectures and verbal training. The administrator failed to disseminate the information to the rest of the facility. The documentation training of the administrator was only located at one facility and copies was not shared of administrator file at Jamestown court. The administrator failed to make copies of infection training to her file at the other facilities. The Administrator had a repeated training of Infection control now and appointed secondary person responsible for the facility infection control program to the facility. The Administrator will update the communication among staff to ensure that all the training information is disseminated to all staff members promptly. The administrator will re -train staff members on the infection program. The administrator requested the secondary person to complete the required training on a required timeframe for compliance. The Administrator will update communication	10/03/2024

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			protocols, tracks training records of staff for compliance yearly. The Administrator will ensure that it will not recur again the oversight of important training to the facility. The administrator will ensure the other staff in the facilities is aware on the new infection control designee if the main administrator is not available. Tag #1825 The name of the Primary Person responsible for Infection Control in the Facility is Freda Castro, The Administrator and the Secondary Person responsible for Infection Control in the facility is Gerome Andres. He is the Assistant Manager in the facility.	
1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on personnel file review, document review, and interview, the facility lacked a primary and secondary infection control person with the required infection control training per Legislative Counsel Bureau File Number R048-22, Section 5, with the potential to affect 7 of 7 residents. Findings include: On 08/26/2024	1830	Tag 1830 Infection Control required Training-Infection Control required Training LCB File No R048 -22 Sec 5.4. The person designated pursuant subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infection provided by association for Professionals and Infection control and epidemiology of America. The facility lacked a primary and secondary infection control person with required infection control training course per Legislative counsel Bureau file Number R048-22 section 5 with potential to affect 7 of 7 residents. The Administrator had completed the training with other staff last year, but the documentation training was not distributed to the different files of the administrator. The Administrator had training last year but administrator had failed to disseminate the information to the rest of the facility and staff. The administrator had retaken the 20 hours of Infection control training, and the assigned secondary person had taken his training and took 20 units of Infection Training Course. The administrator of the facility will ensure to disseminate infection control training information and communicate among staff who is the	10/03/2024

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	at 2:23 PM, the Assistant Administrator confirmed the required infection control and prevention training had not been completed by any employee working in the facility. Severity: 2 Scope: 3		secondary personnel, so everyone is aware to whom to report if there is question about certain illnesses in the facility in the absence of administrator. The administrator will ensure to monitor employee files for updated training yearly for infection control and other training records for compliance with infection training and others. Established communication among staff that training should be taken immediately for compliance. The Administrator will instruct all caregivers about the importance of the training in the facility to broaden the caregiver's knowledge in help and prevent and stop the spread of infections among each caregiver and to the residents in the facility. Please see attachment infection control trainings for Tag 1830 for the administrator and the designee.	
1840 SS= F	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 4 of 5 employees obtained the	1840	Tag 1840 UNL Caregiver Training -R063-21 an Unlicensed caregiver Training-R063-21 Sec. 41l a caregiver that provides care to resident's patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious disease. the training must include without limitation. instruction concerning a) hand hygiene, the use of PPE equipment including without limitation mask, respirators, eye protection, and gloves, envt cleaning and disinfection, the use of source control to prevent pathogens from spreading, must provide proof of completion of the training to the administrator. The administrator failed to have infection control training course for to Employee No 2, # 3, # 4 and # 5. The Administrator of the facility had provided all the Infection training via brochures and verbal discussion in the past, before covid pandemic that my facility had not contracted covid during the pandemic season. Education training through	10/03/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT CARE GROUP HOME 2	3238 JAMESTOWN COURT, SPARKS, NEVADA ,89431

(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
	required infection control training required per Legislative Counsel Bureau File Number R063-21, Section 4 with the potential to affect 7 of 7 residents (Employees #2, #3, #4, and #5). Findings include: Employee #2 Employee #2 was hired by the facility as a Caregiver with a start date of 02/27/2016. Employee #2's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. Employee #3 Employee #3 was hired by the facility as the Assistant Administrator/Caregiver with a start date of 03/22/2017. Employee #3's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 04/25/2023. Employee #4's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. Employee #5 Employee #5 was hired by the facility as a Caregiver with a start date of 07/25/2024. Employee #5's personnel file lacked documented evidence of training concerning the control and prevention of infectious diseases as required by the regulation. On 08/25/2024 at 2;23 PM, the Assistant Administrator acknowledged the lack of documented evidence of required infection control training in the personnel files for Employee #2, #3, #4, and #5. The Assistant Administrator verbalized the infection control training had not occurred. Severity: 2 Scope: 3		brochures, question and answers and one-to-one in-service with the staff was provided like hand hygiene downing and doffing and N95 usage and resp infection control, cleaning and disinfection of high touch areas, resulted to no one got sick of covid, no one got sick during the pandemic, Also c-diff,VRE, UTI s/s, pneumonia s/s, flu s/s were discussed. The administrator was glad that the CDC is providing this training and now it's free of charge to help all the other caregivers to have knowledge and opportunity to learn more about infection control of the daily life and other topics in cutting the spread of infection. The caregivers were enrolled in this free training class and deadlines to turn in the certificate was instructed to complete the infection control for non-professional to comply with the requirement per legislative counsel Bureau File Number R063-21, section 4. The administrator will ensure each employee take this important training and to monitor employee's file training yearly by periodic reviews of training records. The Administrator will do walk in audits to caregivers if handwashing and alcohol foam, cleaning and disinfecting use are being applied in the facility for prevention of infection. The corrective actions and good communications among staff and administrator will be implemented. To notify the administrators right away for first symptoms of illness among resident so protection to other residents will be implemented right away. Please see Attachment TAG 1840 for infection control training Certificate of Caregiver #2, #3, #4, #5	