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 _____	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT CARE GROUP HOME II	**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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey and complaint investigation initiated at your facility on 10/20/2025 and finalized on 11/06/2025. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. Six resident files and three employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Complaint #NV00073764 could not be substantiated. There were no regulatory deficiencies identified. The investigation included: Observation of the interior and exterior of the facility, including the backyard and resident bathrooms, resident to resident interactions, and staff to resident interactions. Interviews were conducted with residents, Caregivers, and the Administrator. Clinical record review of six records, which included the resident of concern. Document review including the facility's policies and procedures.			
Y 0051 SS= D		Y 0051	Tag Y 0051 Findings were not updated administrator designee was posted.	05/26/2026

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	NAC 449.194 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. Inspector Comments: Based on observation, document review, and interview, the Administrator failed to ensure an employee was assigned as the Administrator Designee in the absence of the Administrator. Findings include: On 10/20/2025 at 9:41 AM, the posted Administrator Designee notification named an employee who was not at the facility. A Caregiver verbalized the posted Administrator Designee worked at another facility and only filled in on occasion. On 10/20/2025 at 1:06 PM, during a phone interview, the Administrator confirmed the employee posted as the Administrator Designee no longer worked for the facility. The Administrator explained the employee		The administrator of the facility had removed the outdated posting immediately upon notification. A new, accurate posting identifying the current designated employee in charge was created and placed in required location. All caregivers were informed of the updated designation to ensure clarity regarding supervisory responsibilities. To ensure ongoing compliance and to prevent recurrence, the administrator has established a procedure requiring administrative review of all postings weekly to ensure accuracy or the designation verification process. The administrator will ensure that immediate regulatory postings will be remove or updated with change of roles of employees such as termination or resignation with in 24 hours. The administrator has updated protocols that the designated administrator is now responsible for updating " employee in Charge" posting whenever staffing changes occur. The administrator had re-educated all caregivers on regulatory requirements regarding accurate postings and the importance of maintaining up to date information thru staff meeting. The administrator will conduct monthly audits of all required postings every month. Any discrepancies will be corrected immediately and addressed through retraining if necessary. The administrator of the facility will have ongoing monitoring of regulatory requirement posting of the facility to ensure compliance. The Administrator of the facility will assign a designee or employee at all times in the absence of the administrator, so the designee has all access to confidential information of the patients and employees. The administrator of the facility will ensure that there will be a current and updated designee posted in the public to view at all times in the absence of the administrator. Please see Attachments.	

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	had not worked at the facility for a "few months" and confirmed the Administrator had not appointed another employee as the Administrator Designee prior to 10/21/2025. Severity: 2 Scope: 1			
Y 0074 SS= D	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually receive training to recognize and prevent theabuse of older persons before the license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse of older persons before the facility, agency	Y 0074	Y 0074 The employee completed the required elder abuse training immediately upon discovery of the deficiency. The administrator had placed the completed training documentation on employee's personal profile. To ensure full compliance moving forward, the administrator of facility has implemented the following corrective systems. A training log has been created to track all mandatory training deadline for each employee. The administrative staff will send reminders 30 days, 14 days before training is due. The administrator or designee will review training records monthly to ensure all staff remain current with required trainings. The administrator has been re-educated of the importance of timely completion of elder abuse training and the regulatory requirement associated with it. The administrator will do close monitoring of employee's files by monthly audit of staff training files for compliance to ensure no missed or out compliance. Any employee found to be out of compliance will be immediately removed from resident care until training is completed. Audits will be reviewed during monthly staff meeting to reinforce accountability. The administrator will have ongoing monitoring as outline above for regulatory compliance. The employe #1, was late for less than a month to have the elder abuse training on time. The administrator will ensure to monitor and update Employee #1's training certification on time and will do monthly review of personnel records to prevent lapses of training on elder abuse. The Administrator will track and monitor closely the trainings of all personnel of the facility so this occurrence can be prevented and	05/26/2026

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	or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care, facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter. 6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section.		will not be repeated again. The Administrator had sent the recent elder abuse training of employee #1. Please see attachment. Tag 0074	

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	8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection. 9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1 of 3 employees completed Elder Abuse training annually. (Employee #1). Findings include: Employee #1 Employee #1 was hired as the Administrator on 02/16/2006. Employee #1's personnel record documented Elder Abuse training completed on 03/09/2024 and again on 04/03/2025, approximately one month after the training was to be completed. On 10/20/2025 at 1:06 PM, the			

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	Administrator confirmed the Administrator had not completed Elder Abuse training on or before the trainings annual due date. Severity: 2 Scope: 1			
Y 0930 SS= D	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's	Y 0930	Y0930 The Resident #5 had tb test on 11/8/2023 when the resident #5 was admitted to the facility. Resident #5 should have TB test on NOV 2024 for her annual but somehow it was missed and no TB test results that was done on month of NOV 24. So QuantiFERON gold testing was requested to the son immediately after the findings. The administrator immediate action was taken. The resident received the TB skin testing immediately upon discovery of the oversight. The resident was monitored for symptoms, and no signs of TB was observed during the lapse. The documentation of the completed TB test has been added to the resident's medical file. All residents TB record were reviewed to ensure no other screenings is overdue. The facility administrator has implemented the following corrections to ensure the issues does not occur again. The administrator had created a centralized tb screening log for all residents including due dates completion dates and follow them up. The administrator of the facility will ensure to frequently monitor every month the residents file and tracking log has been created to ensure ongoing compliance for all resident's records for up-to-date information about tb testing records to avoid missing TB test on time. The administrator will do every month resident's chart review to all resident files to ensure the yearly tb test are all up to dates. The facility has implemented a TB Screening Compliance Checklist that must be completed during admission and annually thereafter to prevent recurrence.	05/26/2026

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	allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident;		The paper chart now includes a mandatory TB screening field that must be completed. A monthly health record audit will be conducted by the administrator to ensure all required screenings are current. The administrator of the facility will review the TB Screening Log and resident health record monthly for monitoring to ensure ongoing compliance. Any discrepancies will be corrected immediately and addressed on time. The Administrator of the facility had trained all employees about the tb test tracking log in the facility, that staff need to help check and monitor monthly the TB tracking log for any TB test due. Result of latest Tb test of Resident #5 tb test was sent and please see attachments.	

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	(2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the			

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	death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure 1 of 6 sampled residents (Resident #5) completed testing for tuberculosis (TB) annually. Findings include: Resident #5 Resident #5 was admitted to the facility on 11/08/2023, with diagnoses including hypertension and vitamin D deficiency. A laboratory (lab) report documented Resident #5 was tested for TB on 02/12/2025, by QuantiFERON blood test. The residents clinical record did not include documentation of additional testing. On 10/30/2025, in an email, the Administrator explained a TB test should have been completed for Resident #5 in November 2024. The Administrator confirmed the TB test was not completed in November 2024, but was completed on 02/12/2025, approximately three months late. The Administrator was unable to provide any additional documentation of testing. Severity:2 Scope:1			

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Y 0920 SS= D	NAC 449.2748 Medication Storage. 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 without supervision may keep his medication in his 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. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation	Y 0920	Y 0920 The medication cabinet was immediately closed and secured at the time of inspection. The staff involved was given immediate re-education on medication security protocols. No residents accessed or were exposed to unsecured medications during the incident. All caregiver and staff with access to medications received retraining on regarding proper medication storage. Requirements for maintaining locked and attended medication areas. Immediate reporting procedure for any breach. The administrator of the facility had educated all staff a mandatory "lock and check" steps whenever a staff steps away from the medication cabinet. A prohibition on leaving medication storage areas open for any reason. The administrator of the facility placed a reminder sign ("Medication Cabinet Must Remain Locked at All Times ") was placed above the medication cabinet. The administrator will conduct random medication storage twice weekly for 8 weeks then monthly for six months for monitoring and compliance. Any non-compliance will result in immediate corrective action and retraining. The administrator had Inservice and reviewed medication management and storage. Emphasized the medication cabinet should be locked at all times when medication not being actively administer. A reminder note on medication cabinet was posted "medication cabinet must remain locked at all times, to remind staff that no medications cabinet should be left unattended and not locked. Please see attachment and in-service.	05/26/2026

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	and interview, the facility failed to ensure a cabinet containing resident medications was locked at all times when medications were not being actively administered. Findings include: On 10/20/2025 at 9:31, the medication cabinet was unlocked, and an employee was not at or near the medication cabinet. On 10/20/2025 at 9:31 AM, Employee #2 locked the cabinet and confirmed the cabinet contained resident medications and had been left unlocked and unattended. The facility policy titled "Medication Management and Storage", revised 08/02/2023, documented all medications must be stored in a locked cabinet or medication cart and accessible only to authorized staff. Severity: 2 Scope: 1			
Y 1825 SS= D	**NAC 449.0109 Designation and training of person responsible for infection control.** 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. 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	Y 1825	Y1825 The administrator has appointed immediately a qualified staff member as the Infection Prevention Designee Employee #2 on Oct 21,2025. The newly assigned designee completed a review of current infection control policies and procedures and began oversight duties immediately. The administrator completed a review of all infection control documentation to ensure no critical task were missed during the vacancy. The administrator did a full review of infection control logs, incident report and staff training records was conducted in Oct 21,2026 to ensure no gaps in infection prevention practices occurred during the period without a designated Infection Preventionist Designee. The administrator had found no infection - related incident or lapses in resident care were identified and staff were educated to confirm understanding of infection control	05/26/2026

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	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 observation, document review, and interview, the Administrator failed to ensure 1) a designee was assigned to serve in the role of Infection Prevention when the primary designee (The Administrator) was absent, and 2) the Administrator/Infection Control completed infection control training annually. This deficient practice had the potential to result in lapses in infection control resulting in the spread of illness to the residents residing in the facility. Findings include: Infection Control Designee On 10/20/2025 at 1:06 PM, during a phone interview, the Administrator confirmed the employee who was the Administrator's designee for Infection Control during the absence of the Administrator no longer worked at the facility. The Administrator confirmed the Administrator was the primary person in charge of Infection Control.		procedure during transition period. The administrator had implemented changes to prevent recurrence. The facility's Infection Control Program Policy was updated to require, Immediate assignment of a temporary or permanent infection Prevention Designee upon resignation, leave or vacancy. A written documentation of the designee assignment with in 24 hours of any change. The administrator and management team receive retraining on Oct 21, 2025, regarding regulatory requirements for maintaining continuous infection prevention oversight. The administrator or designee will verify the active infection prevention designee assignment monthly, ensuring the role is continuously filled. A quarterly audit of infection control documentation will be conducted to ensure ongoing compliance with state regulation. Any Lapse in assignment or oversight will result in immediate corrective action and retraining. The Administrator will ensure that there will be appointed and assigned infection control designee at the facility all the time, to serve as the role of infection control when the primary designee for infection control is absent. The administrator will monitor the secondary infection control designee to have 15 hours of training yearly concerning the infection control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, inc. The centers for Disease Control and Prevention in United States, The World Health Organization, the Department of Health and Human Services. The certification of training must be maintained in the personnel file immediately after the training. The Administrator will ensure the secondary designee has all the current infection control training of 15 hours about infection control and it should be in the file of personnel as secondary infection control and should be completed soon after assigning and designating	

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 _____	10/20/2025

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	On 10/202/25 at 1:06 PM, the Administrator explained the employee had not worked at the facility for "a few months" and confirmed the Administrator had not appointed anyone else to serve as the Infection Prevention designee the absence of the Administrator/Infection Control. Infection Control Training Employee #1 Employee #1 was hired as the Administrator on 02/16/2006. Employee #1's personnel record lacked documentation of Infection Control training. On 10/20/2025 at 1:06 PM, the Administrator confirmed the Administrator had not completed Infection Control training annually. The Administrator was unable to provide documented evidence Infection Control training was completed prior to 10/20/2025. On 10/30/2025, in an email, the Administrator confirmed the Administrator had not completed Infection Control training annually. Severity: 2 Scope: 1		The Administrator will ensure to monitor, all personnel's training to have the annual infection control training yearly and all of the training will be kept on employee's file. The Administrator will do employee personnel's audits monthly to ensure all employee's file are current and no training are being missed. The Administrator and the infection control designee will take 15 hours of Infection control training annually, and the rest of the caregiver will take 8 hours of infection control training from the allowed training course available provided by the Association for Professional in Infection controls like the CDC and Department of Health and Human Services, World Health Organization and all training certification will be kept in personnel's file. The Administrator will ensure to track the personnel's file, to check all the certifications and training every month of all personnel including Employee#1 file, to ensure certifications and other trainings are all current and updated. The Employee #1 is the primary designee as infection control in the facility and Employee #1 is responsible for infection control and prevention of infections in the facility. The administrator will ensure that if administrator is not available a designee is responsible on the administrator's absence. The administrator is responsible to ensure the infection control designee is current with all the necessary infection control training hour of designee every year, The administrator will ensure to frequently monitor the infection control training of personnel file for compliance. The Employee #1 had completed her annual Infection Control Training and added to her personnel's file. All the current Infection control Training was attached. please see attachments. The administrator of the facility had made a tracking log for all employee's trainings needed by all the personnel in the facility and including the due date file for infection control training for employee #1.The administrator will review all personnels files	

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			every month to ensure, all personnel are all current with the required certifications and trainings of all employee's including employee's #1 file. Please see attachments.	