DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME II	**3045 SOUTH TIOGA WAY, LAS VEGAS, NEVADA ,89117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 03/17/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was ten. The sample size was five. The facility received a grade of B. There was one complaint investigated. Substantiated: 1. Complaint #NV00073359 was substantiated. (See TAGs Y050, and Y0590) The investigation of the Complaint included: Observation of resident's mail, residents interactions with staff and a tour of the facility. Interviews were conducted with the resident of concern, residents, Caregivers, the Administrator and the Manager/Property Owner. Clinical Record Review of five records which included the resident of concern. Document Review included the resident of concern's digital checks written to the facility, State of Nevada Department of Motor Vehicles car title records, public property records, and facility policy and procedures, The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0050 SS= G	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS.	0050	1. To address the specific citation, an immediate review of the residence file was conducted to ensure the resident receives the necessary services and protective supervision. This review included evaluating capacity statements or guardian or POA referrals if necessary, comprehensive care plan, protective supervision log and removing facility manager from billing. 2. To prevent recurrence of the citation, a systematic change was made to the policy	05/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: REBECCA N WOLFKILL | Title: Administrator | Date: 05/07/2025

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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	Inspector Comments: Based on interview, record review, and document review the Administrator of the facility failed to provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents received needed services and protective supervision for 1 of 5 sampled residents. (Resident #1) Findings include: R1 was admitted to the facility on 09/11/23, with diagnoses including congestive heart failure and dementia. A Hospital Discharge Summary from a local hospital, dated 08/12/23 documented R1's discharge diagnoses were an age-related disability and acute encephalopathy. R1 had presented to the hospital due to a fall and was documented as having chronic pulmonary fibrosis, dementia, depression, anxiety and an altered mental status. A Rehabilitation Center Interdisciplinary Discharge Summary dated 09/11/23 documented R1's cognitive skills for daily decision making regarding the tasks of daily life were moderately impaired and R1 never or rarely made decisions. R1's mental status upon discharge was documented as only being alert to person. A Residential Lease Agreement signed by R1 dated 09/11/23 documented R1 would pay the facility $5500.00 every 11th day of the month for a private room, care and board only. R1's banking records documented nine checks from 10/1/2023 through 8/9/2024 were written in the amount of $5500.00 and signed by R1. The body of the checks appeared to have different handwriting than R1's signature. A Relinquish Form dated 10/10/23 documented R1 would sell R1's condominium for $30,000 plus closing costs incurred to the group home Manager, Employee #4 (E4), as the property required a full renovation. The Relinquish Form was signed by R1 with R1's Financial Power of Attorney signing as a witness. State of Nevada Motor Vehicle Records documented R1's 2006 Lincoln 4 door		on Resident financial and property safeguards, explicitly prohibiting staff from acquiring residence assets. 3. To ensure the deficient practice does not recur, the corrective action will be monitored through monthly audits by the administrator by ensuring that protective supervision policy is being enforced. 4. The administrator is responsible for ensuring the implementation and enforcement of the plan of correction 5. Corrective action was done May 5,2025	

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	sedan had a Title Transaction date of 10/23/23 which transferred the title from R1 to the group home Manager (E4) and was then registered by the group home Manager (E4) on 11/28/23. Real Property Transaction Record documented an 11/02/23 transaction where the group home Manager (E4) purchased R1's condominium. The recording date was documented as 11/08/23. A Certification of Competency from a Physician dated 09/11/24 documented R1 was not sufficiently competent to execute and understand the nature of a durable power of attorney for healthcare and durable power of attorney for financial decisions and the delegation of authority to an agent. R1's physician documented R1 did not have the capacity to make any decisions. R1's file documented R1 had a Financial Power of Attorney (POA) as of 2018. The file lacked documented evidence the facility had attempted to obtain a public or private guardian for R1 upon admittance with the mental status of only being alert to person or after the certificate of Competency dated 9/11/24 which documented R1 did not have the capacity to make any decisions. On 03/17/25 in the morning, R1 was unable to remember who their Financial Power of Attorney was. R1 reported having only paid the facility approximately $400 on two occasions for rent at the facility. When asked what year it was, R1 verbalized it was the year 2000. On 03/17/25 in the morning, the Administrator acknowledged the group home Manager (E4) should not be taking possession of residents' real estate and vehicles. According to the Administrator, the Administrator had nothing to do with the billing process and was unaware of documentation in R1's file. On 03/31/25 in the afternoon, E4 acknowledged managing the facility. E4's duties were buying groceries for the facility, sending out billing statements, writing the staffing schedule and transporting residents to their appointments. R1 currently resided at the			

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	property and E4 verbalized purchasing R1's property and vehicle as a favor to R1. According to E4, E4's husband owned the group home business and E4 owned the group home property. Severity: 3 Scope: 1 Complaint# NV00073359			
0100 SS= D	Personnel File - NAC 449.200 & R043-22 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: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee, including, without limitation: (1) Certificates of completion for all training completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the training or an outline of the training; (e) Evidence that the references supplied by the employee were checked by the residential facility. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 Employees had a completed employee file (Employee #4). Findings include: Employee #4 (E4) E4 was hired on or around 2018 as a Manager. E4 did not have an employee file located at the facility. E4 had no documentation of hire date, training, personnel information or reference checks. On 02/18/25 in the morning, a Nevada Automated Background System (NABS) report for the facility documented E4 was the Admissions and Office Manager for the facility. E4 had their fingerprints taken on 01/18/23 with a determination date of 02/07/23. On 03/17/25 in the morning, Employee #1 confirmed Employee #4 was	0100	1. In order to address this deficiency, the personnel file, as required was completed. 2. In order for this deficiency not to recur, personnel files must be completed and retained at the facility at all times. 3. In order to ensure that this efficiency practice will not recur, all personnel files are maintained at the facility and made readily accessible for review at any given time. 4. The administrator will be responsible for ensuring that the plan of correction is implemented. 5. The corrective action was done on March 17, 2025	04/17/2025

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	the Manager of the facility and verbalized E4 bought groceries for the facility and sent out the invoices via email. Employee #1 acknowledged E4 had no employee file onsite. On 03/17/25 in the morning, the Administrator acknowledged E4 was the Owner and Manager of the facility. According to the Administrator, E4 sent out bills and the Administrator has nothing to do with the billing process. On 03/31/25 in the afternoon, E4 reported they were the facility Manager and verbalized being responsible for resident files and sending billing invoices. According to E4 they bought groceries for the facility, created the staffing schedule and transported residents to their appointments. Severity: 2 Scope: 1			
0590 SS= G	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on interview, record review and document review the Administrator failed to ensure 1 of 5 sampled residents was not exploited by a member of the staff of the facility. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted to the facility on 09/11/23, with diagnoses including congestive heart failure and dementia. A Hospital Discharge Summary from a local hospital, dated 08/12/23 documented R1's discharge diagnoses were an age-related disability and acute encephalopathy. R1 had presented to the hospital due to a fall and was documented as having chronic pulmonary fibrosis, dementia, depression, anxiety and an altered mental status. A Rehabilitation Center Interdisciplinary Discharge Summary dated 09/11/23	0590	1. To address this citation, an independent legal counsel was retained by Sunshine Care home II to finalize transactions involving Resident 1 and to ensure the resident is not being exploited. The manager involved in this transactions has been removed from all financial and property related responsibilities. All financial request must now be routed to the Administrator through the resident's legal guardian. 2. Systematic change has been implemented to prevent recurrence of this deficiency by incorporating a zero transaction rule into the policy, prohibiting staff from purchasing, receiving, or brokering Resident property. In addition, residents' rights and the exploitation prevention modules are now included in both staff orientation and annual training. 3. To ensure the deficient practice does not the recur, the corrective action will be monitored through a routine reviews statements and random audits conducted by the administrator to identify any financial concerns. Discrepancies will be investigated within three days of discovery. 4. The title of the person who is responsible in implementing this plan of correction is the administrator. 5. Corrective action is done on May 5, 2025	05/05/2025

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	documented R1's cognitive skills for daily decision making regarding the tasks of daily life were moderately impaired and R1 never or rarely made decisions. R1's mental status upon discharge was documented as only being alert to person. A Residential Lease Agreement signed by R1 and dated 09/11/23 documented R1 would pay the facility $5500.00 every 11th day of the month for a private room, care and board only. R1's banking records documented nine checks from 10/1/2023 through 8/9/2024 were written in the amount of $5500.00 and signed by R1. The body of the checks appeared to have different handwriting than R1's signature. A Relinquish Form dated 10/10/23 documented R1 would sell R1's condominium for $30,000 plus closing costs incurred to the group home Manager Employee #4 (E4) as the property required a full renovation. Upon completion of the work, R1 would reside at the property rent free for the rest of R1's life up to 3 years as consideration with the assistance of a caregiver and with the group home Manager's supervision. In addition, R1 would be responsible for all expenses associated with the property including utilities and Home Owners Association (HOA). R1 relinquished all rights, title and interest to the asset. The Relinquish Form was signed by R1 with R1's Financial Power of Attorney signing as a witness. State of Nevada Motor Vehicle Records documented R1's 2006 Lincoln 4 door sedan had a Title Transaction date of 10/23/23 transferring the title from R1 to the Manager of the group home (E4) and was then registered by the group home Manager (E4) on 11/28/23. Real Property Transaction Record documented an 11/02/23 transaction where the group home Manager purchased R1's condominium. The recording date was documented as 11/08/23. A Quit Claim Deed dated 05/14/24 documented the group home Manager put R1's condominium in the		6. Please see attached copies of termination letter, zero transaction rule policy. a) R1 admitted to Sunshine Care Home on 9-11-23. Rehabilitation Center Discharge Summary dated 9-11-23 Ri cognitive skill for daily decision making regarding task of life were moderately impaired. on October 3, 2023 Dr assessment said that R1 is competent to medical and financial decision for himself . Relinquish Form was created on October 10, 2023 between R1 and E4 . Contract Addendum August 26, 2024 between R1 and E4. Administrator not aware of the contract. b) The home of R1 are fully renovated and ready for R1 to transfer. The administrator emailed APS Purite Williams about R1 been crying he doesn't want to go back to his condo anymore. He wants to stay at Sunshine Care Home. c) Schedule of moving date 4-18-25 but R1 refused to leave. d) APS Ombudsman R1 Should stay if he doesn't want to. d) Administrator will monitor for compliance. e) 4-18-25	

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	group home Manager's (E4) trust. Clark County Real Property Records documented the group home Manager (E4) as the Trustee of the trust. A Contract Addendum dated 08/26/24 documented R1 and the group home Manager (E4) entered into a contract dated 10/10/23 for R1 to relinquish all rights, title, and interest to R1's condominium. The Contract was amended on 08/26/24 by adding "2 years rent free" and deleting the phrase, "I will reside at the property rent free for the rest of my life," replacing it with the phrase, "I will reside at the property as long as I'm in good health condition and not terminally ill." The Contract Addendum was signed by R1 and not R1's Financial Power of Attorney. A Certification of Competency from a Physician dated 09/11/24 documented R1 was not sufficiently competent to execute and understand the nature of a durable power of attorney for healthcare and durable power of attorney for financial decisions and the delegation of authority to an agent. R1's physician documented R1 did not have the capacity to make any decisions. A Physical Examination Dated 02/10/25 documented R1 was alert and oriented between 1 and 2. R1 was confused most of time. R1 was documented as being able to state pain. Adult Protective Services (APS) Investigation Summary Report dated 08/19/24 documented on 08/20/24 at 9:09 AM, R1 verbalized to an APS Social Worker that R1's home was sold to the group home Manager (E4). R1 reported an arrangement where E4 would renovate R1's home and allow R1 to move back into the home upon completion of the renovation. According to R1, E4 would find R1 a full-time caregiver and allow R1 to die in their home. R1 reported wanting to move back into their home and being able to die in peace. Adult Protective Services Investigation Summary Report dated 08/19/24 documented on 08/28/24 at 4:57 PM, R1 verbalized to an APS Social Worker that R1's home was sold to the group home Manager, E4.			

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	According to R1, E4 told R1 they could live in their home for free once it was repaired. R1 reported their home needed new carpet, had mold and needed a new roof and E4 was fixing R1's home. R1 verbalized E4 knew a woman who lived in California who had recently divorced and would care for R1 in their home. R1 confirmed R1 had not seen any financial documents, bank statements or real estate documents regarding the sale of R1's home. On 03/17/25 in the morning, R1 was unable to remember who their Financial Power of Attorney was. R1 reported having only paid the facility approximately $400 on two occasions for rent at the facility. When asked what year it was, R1 verbalized it was the year 2000. On 03/17/25 in the morning, the Administrator acknowledged the group home Manager should not be taking possession of residents' real estate and vehicles. According to the Administrator, the Administrator had nothing to do with the billing process and was unaware of documentation in R1's file. On 03/31/25 in the afternoon, E4 verbalized being the Manager of the group home. E4 reported they bought groceries for the facility, sent out billing statements, wrote the staffing schedule and transported residents to their appointments. According to E4 they purchased R1's property and vehicle as a favor to R1. E4 verbalized E4's husband was the owner of the group home business and E4 owned the group home property. Severity: 3 Scope: 1 Complaint# NV00073359			

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure both the front gate, and the front door were secured. Findings include: On 03/17/25 at 8:43 AM when the surveyor entered the property, the driveway gate and the front door were wide open which did not allow the alarm to properly work on the front door to keep residents from wandering out of the facility. There were no Caregivers present in the entryway. The surveyor walked into the kitchen and alerted the Caregivers to the front door being wide open hindering the door alarm from working. The Caregiver explained the front door was open due to other Caregivers exiting the facility. On 03/17/25 at 8:45 AM, the Caregiver acknowledged the front door should have been closed and secured so the alarm could be operational. Severity: 2 Scope: 3	0991	1. In order to correct this citation, the safety standard requiring the gate to remain closed at all times will be enforced. 2. In order for this deficiency not to recur, the facility will ensure that the gate remain securely close at all times in compliance with safety standards. Caregivers assigned on duty will be responsible for maintaining the gate in a locked position at all times. 3. In order for the corrective action to be monitored, Caregivers on duty are required to check the gate on regular basis to ensure that standard for safety are observed. 4. Lead Caregiver and ADMINISTRATOR will be responsible for ensuring the plan of correction is being implemented. 5. Corrective action was done on March 17, 2025	04/17/2025