

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4787	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER SUNSHINE CARE HOME II		STREET ADDRESS, CITY, STATE, ZIP CODE 3045 SOUTH TIOGA WAY, LAS VEGAS, NEVADA ,89117		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 07/31/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files and four employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiency was identified:			

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 Name: REBECCA WOLFKILL Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 08/07/2025

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(X4) ID PREFIX TAG 0620 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0620	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 08/07/2025
	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a waiver, to maintain a resident who was bedfast, for 1 of 10 residents (Resident #9). Findings include: Resident #9 (R9) R9 was admitted on 06/27/25 with diagnosis including stage four pressure ulcer and chronic kidney disease. On 07/25/25 in the morning, R9 was observed lying flat in bed. R9 indicated they could not turn on their side without assistance from staff. On 07/31/25 in the morning, a Caregiver indicated they helped turn R9 on their side multiple times a day, because R9 cannot turn on their own. Review of R9's medical record did not reveal a bedfast waiver. On 07/31/25 in the morning, the Administrator confirmed they did not have an approved bedfast waiver for R9. Severity: 2 Scope: 1		1) To correct a specific deficiency, the caregiver will check regularly if the resident can change position left to right by herself without the help of another person. If the resident cannot move by herself then Bedfast Waiver should apply Permission to Retain. 2) To make sure that this deficiency will not occur again, the lead caregiver and administrator will perform daily assessment to the resident. 3) The corrective action will be monitored by lead caregiver and administrator daily. 4) The responsible persons to make sure that the plan of correction is implemented are administrator, owner and lead caregiver. 5) Corrective action was done August 2, 2025.	