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 _____	**07/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CESSABELLA RESIDENTIAL SUITE LLC #1	**8295 OPAL STATION DR, RENO, NEVADA ,89506**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and complaint investigation State Licensure survey completed in your facility on 07/15/2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly or disabled persons, and/or persons with mental illness, and/or persons with chronic illness, Category II residents. The census at the time of the survey was eight. There were two complaints investigated. The facility received a grade of B. Complaint #NV00024320 with the following allegations was substantiated: -Allegation #1: The front primary exit door of an unlocked facility was locked with a bolt and a key was required to unlock the door from the inside (See Tag Y445). -Allegation #2: A caregiver was unable to demonstrate the ability to speak and understand the English language (See Tag Y065). The following allegations could not be substantiated due to a lack of sufficient evidence: -Allegation #3: A caregiver restrained a resident by holding a bedroom door closed with the resident inside. -Allegation #4: The facility telephone was not in working order. -Allegation #5: Resident-to-resident physical abuse occurred when a resident was kicked by another resident. Complaint #NV00024580 with the following allegations was substantiated: -Allegation #1: The front primary exit door of an unlocked facility was locked with a bolt and a key was required to unlock the door from the inside (See Tag Y445). -Allegation #2: A caregiver was unable to demonstrate the ability to speak and understand the English language (See Tag Y65). The following allegations could not be substantiated due to a lack of sufficient evidence: Allegation #3: Employee-to-resident abuse occurred when a caregiver git a resident in the face, eye,	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EVA BELTEJAR Title: Owner Date: 11/04/2025

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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	and cheek. Allegation #4: A caregiver restrained a resident by holding a bedroom door closed with the resident inside. The investigation into the allegations included: Observations of the environment, residents in their room and common spaces, the primary exit door, use of the facility cell phone, facility postings, and resident to staff interactions. Interviews were conducted with five residents, including residents of concern, two caregivers, and the Business Office Manager. Resident clinical record review included admission dates, diagnoses, person-centered service plans, progress notes, and physician placement determinations. Employee record review included hire dates, elder abuse prevention training, and mental illness training. The investigation revealed the Administrator failed to ensure an initial standard physician placement determination was completed for a resident, a resident with a standard physician placement determination the resident was in need of a facility endorsed for the care of persons with Alzheimer's disease was not retained in the facility, and the facility maintained complete personnel records (See Tags Y053, Y960, and Y1700). The findings and conclusions of any investigation by the Health Care Purchasing and Compliance Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0053 SS= F	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on personnel record review and interview, the Administrator failed to ensure the facility maintained completed personnel records for	0053	1. To correct the specific finding, Employee #6 wasimmediately removed from the schedule on 07/15/2025 until all personneldocuments were completed. A full personnel file has been created to includeapplication, background check clearance, TB/medical clearance, requiredcaregiver training and orientation, job description, emergency	10/25/2025

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	1 of 6 employees (Employee #6). Findings include: Employee #6 Employee #6 was hired as a caregiver, hire date unknown. On 07/15/2025 at 9:41 AM, upon entrance to the facility, Employee #6 pushed a resident in their wheelchair from the front porch into the facility. On 07/15/2025 at 9:54 AM, Employee #6 was in the kitchen assisting another caregiver prepare food. On 07/15/2025 at 11:25 AM, Employee #6 asked a resident if the resident needed anything, gave a hug to the resident, and exited the room. The facility was unable to provide a personnel file for Employee #6. On 07/15/2025 at 11:44 AM, the Business Office Manager (BOM) verbalized Employee #6 started as a caregiver at the facility approximately one week prior. The BOM explained Employee #6 previously worked at another facility from the same owner; however, was "testing the waters" to determine if this facility would be a better fit for Employee #6. The BOM confirmed Employee #6 has been working on the floor with direct contact to the residents, and confirmed the facility did not have a personnel file for Employee #6. Severity: 2 Scope: 3		contactinformation, and CPR/First Aid certification. Employee #6 returned to duty onlyafter full compliance with hiring requirements. 2. To ensure the deficient practice does not recur, thefacility has implemented a policy that no employee may begin work or haveresident contact without a fully completed personnel file. A Personnel FileChecklist must now be completed and signed by the Administrator or BusinessOffice Manager prior to the start of any new employee, including stafftransferring from sister facilities. The hiring process has been updated torequire full onboarding at this facility regardless of prior employment underthe same owner. 3. Corrective actions will be monitored through monthlypersonnel file audits for six months, documented in the Personnel File AuditLog. The Administrator or BOM will verify completion of all personnel filedocuments before assigning any employee to the schedule. Any future incompletefiles will result in immediate removal from duty until all requireddocumentation is verified. Audit results will be reviewed in monthly QAmeetings. 4. The Facility Manager and Owner/Administrator will beresponsible for implementing and maintaining this plan of correction. 5. Completion date: 10/25/2025. 6. All pertinent documents uploaded. 7. To identify and correct other areas that may beaffected, a full audit of current personnel files was completed and anyincomplete files were immediately	

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			corrected. All current employees have beenconfirmed to have complete and compliant personnel records.	
0065 SS= F	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on observation and interview, the facility failed to ensure a caregiver met the qualifications related to the ability to speak and understand the English language for 1 of 6 employees (Employee #5). This deficient practice had the potential to place all residents in the facility at risk for harm. Findings include: Employee #5 Employee #5 was hired at the facility as a caregiver on 06/25/2018. On 07/15/2025 at 9:45 AM, a resident	0065	1. To correct the specific finding, the facility verifiedthat Employee #5 is able to communicate in English and has been effectivelyperforming caregiving duties, but becomes nervous speaking English due toaccent and confidence, which impacted responses during the inspection. Employee#5 communicates using basic English, visual cues, gestures, and a translatordevice as needed. Residents have confirmed they understand her with thesemethods, and Employee #5 is ALWAYS paired with another English-proficient caregiverwhile on duty to ensure clear communication and resident safety. The facilityreviewed expectations with Employee #5 and reinforced use of verbal English inresident care interactions. 2. To ensure the deficient practice does not recur, thefacility has reinforced its policy requiring all caregivers to demonstrateEnglish communication ability upon hire and annually. Staff were re-educated oncommunication requirements and available tools to support residentunderstanding. The facility also formalized a practice of pairing caregiversrequiring communication support with an English-proficient team member. 3. To monitor compliance, the Administrator or designeewill conduct monthly conversational competency checks and observe interactionsinvolving Employee #5 for six months, documenting progress and confidence. Anyidentified concerns will	10/15/2025

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	verbalized Employee #5 had worked as a caregiver in the facility for at least four years. The resident verbalized Employee #5 assisted with meals, toileting, and changing clothes. The resident explained Employee #5 did not understand English and did not speak English to the residents. On 07/15/2025 at 9:54 AM, a second resident explained Employee #5 did not speak any English to the residents and the resident needed to use situational cues in an attempt to understand when Employee #5 spoke. On 07/15/2025 at 11:07 AM, an interview was attempted with Employee #5 in the facility kitchen. A question of "how are you today?" was asked, and Employee #5 responded with the employee's name. The question of "how are you doing today?" was repeated, and the employee responded, "I am in the kitchen." The question of "How long have you worked at this facility?" was asked, and Employee #5 did not respond verbally, however gestured to the room. On 07/15/2025 at 11:08 AM, Employee #6 apologized and verbalized Employee #5 did not understand English. Employee #6 answered the previous question directed toward Employee #5 and verbalized employee #5 had worked at the facility for four years. On 07/15/2025 at 11:44 AM, the Business Office Manager (BOM) verbalized Employee #5 was a caregiver and assisted with transfers, food, and medication administration. The BOM confirmed speaking and understanding English was a requirement to be a caregiver and explained caregivers needed to communicate with residents to identify resident needs. Complaint #NV00024580 and #NV00024320. Severity: 2 Scope: 3		result in additional coaching and support. 4. The Facility Manager and Owner/Administrator will beresponsible for implementing and maintaining this plan of correction. 5. Completion date: 10/15/2025. 6. All pertinent documents uploaded. 7. To identify and correct other areas potentiallyaffected, a review of all caregiver communication competency records wascompleted, confirming all staff meet English-communication requirements. Anyfuture staff needing communication support will receive language coaching andjob-paired support to ensure full compliance and resident safety.	
0445 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 3. An exit door in a residential facility must not be equipped with a lock that requires a key to open it from the inside unless approved by the State Fire Marshal or his or her designee.	0445	1. To correct the specific finding, the deadbolt requiringa key from the inside was immediately removed from the primary exit door. Thefacility confirmed that all exit doors now allow residents to exit freelywithout the use of a key, tool, or staff assistance. The back exit	11/01/2025

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	Inspector Comments: Based on observation and interview, the facility failed to ensure the primary exit door was not equipped with a lock requiring a key to open from the inside. This deficient practice had the potential to affect all residents in the facility. Findings include: The facility license, effective 01/01/2025, lacked documentation of an Alzheimer's and dementia endorsement. On 07/15/2025 at 9:40 AM, the primary exit door was equipped with a deadbolt above the door handle requiring a key to unlock on both sides of the door. A key was located in the deadbolt on the inside of the door. On 07/15/2025 at 9:41 AM, the facility Caregiver, turned the deadbolt to the locked position and removed the key. On 07/15/2025 at 9:45 AM, a resident explained approximately five months prior, the facility added the deadbolt lock to the front primary exit door. The resident verbalized the staff kept the door locked. The back primary exit door was not locked; however, was difficult to open. The resident expressed concern without access to the key or staff, the resident would be unable to get out of the house should a fire occur. On 07/15/2025 at 9:54 AM, a second resident explained the front primary exit door was always locked to prevent residents from wandering around the neighborhood. The resident verbalized the resident was required to ask staff to unlock the door to leave the facility. On 07/15/2025 at 11:44 PM, the Business Office Manager (BOM) confirmed the deadbolt lock on the front primary exit door required a key to lock and unlock the deadbolt. The BOM explained the facility installed the deadbolt lock because some residents of the facility had exit seeking behaviors and were not cognitively safe to leave the facility freely. The BOM confirmed the facility did not have an Alzheimer and Dementia endorsement and was not a secured facility. The BOM confirmed the deadbolt lock could act as a fire hazard preventing residents from exiting		door wasserviced and adjusted to ensure smooth and unobstructed opening. All residentswere notified that doors are no longer locked and that they may exit freely.Staff were instructed that key-locking mechanisms on primary exit doors areprohibited without an approved secured endorsement. 2. To ensure this deficient practice does not recur, thefacility has implemented a policy prohibiting installation of any lockingdevice that requires a key, tool, code, or staff involvement to exit on anyprimary resident egress door unless and until the facility receives anAlzheimer's/Dementia secured endorsement. Facility staff were re-educated onresident rights, fire safety egress requirements, and limitations onrestricting resident movement in a non-secured facility. 3. To monitor compliance, the Administrator or designeewill conduct monthly egress-door safety checks for six months to verify exitmechanisms remain unobstructed and compliant. 4. The Facility Manager and Owner/Administrator will beresponsible for implementing and maintaining this plan of correction. 5. Completion date: 11/01/2025. 6. All pertinent documents uploaded. 7. To identify and correct any other areas potentiallyaffected, the facility completed a review of all exit doors, ensuring no othernon-compliant locking devices were present. The review confirmed all otherexits allow free egress, and signage was verified for clarity. Any futureconsiderations for securing exits due to exit-seeking	

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	the facility in an emergency. Complaint #NV00024580 and #NV00024320. Severity: 2 Scope: 3		residents will followproper regulatory pathways, including application for a secured endorsement ifappropriate.	
0960 SS= D	Alzheimer's Care Application for Endorsement - NAC 449.2754 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 1. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or another form of dementia who meets the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 must obtain an endorsement on its license as a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia. A residential facility which offers or provides care for a resident with Alzheimer ' s disease or another form of dementia who does not meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 may obtain such an endorsement.The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Reference - 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. 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	0960	1. To correct the specific finding, the facilityimmediately reviewed Resident #5's admission documentation and confirmed thatthe original physician placement determination was completed incorrectly by theadmitting physician. A new primary care provider reassessed the resident andconfirmed in writing that the current facility is the appropriate placement andthat the resident does not require an Alzheimer's/dementia-endorsed facility.The reassessment documentation has been added to the resident record, and staffwere informed of the updated determination. Resident #5 continues to receiveappropriate supervision and support based on assessed needs. 2. To ensure the deficient practice does not recur, thefacility has updated its admission and clinical review procedures to includeverification of physician placement determinations and clarification from theordering physician when documentation appears inconsistent with a resident'spresentation or care needs. Admission staff have been trained to confirmcognitive-care requirements and to obtain clarification or reassessment from aphysician if the placement form suggests a secured Alzheimer's/dementia endorsement,but the resident's functional status or family/medical information does notsupport that requirement. 3. To monitor compliance, the Administrator will reviewall admission	10/10/2025

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	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. Inspector Comments: Based on interview and clinical record review, the facility failed to ensure a resident, with a physician placement determination, the resident was in need of a facility endorsed for the care of persons with Alzheimer's disease was not retained for admission for 1 of 8 residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 11/06/2024, with a diagnosis of major neurocognitive disorder possible Alzheimer's. Resident #5's clinical record included a physician placement determination dated 11/05/2024, indicating the resident required a facility endorsed for the care of Alzheimer's related diagnosed residents. The facility license, effective 01/01/2025, lacked documentation of an Alzheimer's and dementia endorsement. On 07/15/2024 at 11:44 AM, the Business Office Manager (BOM) explained physician placement determinations were important for residents to receive the right level of care appropriate for them. The BOM explained upon admission, Resident #5 exhibited exit seeking behaviors and left the facility without making staff aware. The facility then installed a deadbolt lock to the front primary door to prevent Resident #5 from leaving again. The BOM confirmed the facility was not endorsed for Alzheimer's and dementia care and Resident #5's physical placement determination indicated the resident should be placed in an Alzheimer's and dementia care endorsed facility. Severity: 2 Scope: 1		packets and placement determination forms before accepting newresidents before admittance. Any questionable, inconsistent, or unclearphysician determinations will trigger a secondary physician clarification orreassessment prior to admission. 4. The Facility Manager and Owner/Administrator will beresponsible for implementing and maintaining this plan of correction. 5. Completion date: 10/10/2025 6. All pertinent documentation has been uploaded. 7. To identify and correct other areas potentiallyaffected, the facility reviewed all current resident placement determinations,diagnoses, and care plans and verified that all residents are appropriate forthe facility's licensure and care level. No other discrepancies wereidentified. Staff were instructed to immediately notify the Administrator iffuture physician placement forms appear inconsistent with resident needs orfacility endorsement level.	
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct	1700	1. To correct the specific finding, the facility locatedthe original physician	10/30/2025

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	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 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		placement determination for Resident #6, which had beencompleted upon admission but was mistakenly filed in the administrative intakefolder rather than the clinical record. The document has since been properlyfiled in the resident's chart, and the clinical record is now complete. Staffresponsible for medical record maintenance have been informed of the filingerror and the correction has been documented. 2. To ensure the deficient practice does not recur, thefacility has revised the admission file handling procedure to require dualverification of all required medical documentation—including physicianplacement determinations—before finalizing an admission packet. 3. To monitor compliance, the Administrator will audit allnew admission files upon admittance to ensure placement determinations areproperly completed, uploaded, and filed in the medical record. Additionally, aquarterly review of resident medical files will be added to the facility'sQuality Assurance process to ensure continued compliance with documentation andfiling procedures. Any discrepancies identified will result in immediatecorrective action and staff retraining. 4. The Facility Manager and Owner/Administrator will beresponsible for implementing and maintaining this plan of correction. 5. Completion date: 10/30/2025. 6. All pertinent documents uploaded. 7. To identify and correct other areas potentiallyaffected, the facility reviewed all current residents' admission	

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CESSABELLA RESIDENTIAL SUITE LLC #1	**8295 OPAL STATION DR, RENO, NEVADA ,89506**

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	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 interview and clinical record review, the facility failed to ensure an initial standard physician placement determination was completed by a provider upon admission for 1 of 8 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 01/17/2025, with diagnoses including dementia, depression, and anxiety. Resident #6's clinical record lacked documented evidence of a standard physician placement determination for the facility. On 07/15/2025 at 11:44 AM, the Business Office Manager (BOM) explained physician placement determinations were important for residents to receive the right level of care appropriate for them. The BOM confirmed Resident #6's clinical record lacked an initial standard physician placement determination. Severity: 2 Scope: 1		documents toconfirm the placement determination forms were properly completed and filed. Noother missing forms were identified, and all records were verified as complete.Staff were instructed to immediately report any future filing inconsistenciesor missing admission documents.	