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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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 annual state licensure survey and complaint investigation completed in your facility on 05/29/2025, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups The facility is licensed for 8 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 eight. Eight resident files and four employee files were reviewed. The facility received a grade of B. There was one complaint investigated. Substantiated: Complaint #NV00073737 was substantiated. (See TAG Y994 and Y1840) The investigation of the Complaint included: Observation included a tour of the facility. Interviews were conducted with residents, a Caregiver, the House Manager and the Administrator. Record Review of four records, which included the employees of concern. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROSALLEN AZUCENA | Title: RFA | Date: 07/01/2025

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.

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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure a pre-employment physical examination was completed for 1 of 4 employees (Employee #3). Findings include: Employee #3 (E3) E3 had a hire date of 10/02/2024, E3's employee file lacked documented evidence of a pre-employment physical examination. On 05/29/2025 in the morning, the House Manager acknowledged E3's employee file lacked documented evidence of a pre-employment physical examination. Severity: 2 Scope: 1	0102	1. Said employee said she submitted a pre-employment Physical Exam but could not find it on her file. Administrator right away requested said employee to get another physical exam from a provider. 2. A list of pre-employment requirements was made by the administrator for future reference. 3. Administrator will regularly check employee files for completion and compliance. 4. The administrator will make sure that POC is implemented. 5. Completed on June 30, 2025. 6. Please see attached copy of the Physical Exam.	06/30/2025

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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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
0620 SS= D	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 and interview, the facility failed to obtain a bedfast wavier for a resident who was bedfast for 1 of 8 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted to the facility on 12/12/2024 with a diagnosis of Cerebral Vascular Accident (CVA). R4 was under the care of hospice. On 05/29/2025 during a facility tour, R4 was observed lying in bed. R4 was unable to reposition or turn without staff assistance. R4's medical record lacked documented evidence a bedfast exemption was obtained. On 05/29/2025 in the morning, a Caregiver indicated R4 was unable to reposition in bed without assistance. The Caregiver indicated R4 was dependent on others for care needs. On 05/29/2025 in the morning, the House Manager acknowledged R4 was bedfast, and verbalized a bedfast wavier should have been obtained for R4. Severity: 2 Scope: 1	0620	1. R4 was discharged from hospice so recently. Home health is now managing her care. Administrator coordinated with the home health agency regarding securing a waiver. Administrator requested a PLAN OF CARE for said resident so she can apply for a bedfast waiver. 2. Administrator made a list of the conditions that a resident may have that requires a waiver. 3. Administrator will carefully evaluate resident's condition before admission so as to apply applicable waiver if needed. 4. The administrator will make sure POC is completed. 5. Completed on June 30 ,2025. 6. Please see copy of a portion of the application for the bed fast waiver.	06/30/2025

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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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
0823 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician; (b) The condition must be cared for by a medical professional who is trained to provide care for and reassessment of that condition; and (c) Before a caregiver provides care to the person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer, the caregiver must receive training related to the prevention and care of pressure sores from a medical professional who is trained to provide care for that condition. Inspector Comments: Based on interview and record review, the facility failed to ensure a wavier was obtained for a resident with a wound for 1 of 8 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/18/2025 with a diagnosis of dementia. R4 was under the care of hospice. On 05/29/2025 in the morning, while conducting a tour of the facility R1 was observed lying in bed. A physical for R1 dated 05/15/2025 documented R1 had a wound on their coccyx, and wound care was conducted two to three times per week by hospice. On 05/29/2025 in the morning, the House Manager verbalized R1 had a wound on the coccyx and hospice cared for the wound two to three times per week. R1's medical record lacked documented evidence a medical exemption wavier for the wound was obtained. On 05/29/2025 in the morning, the Administrator confirmed a medical exemption wavier for the wound was not obtained. Severity: 2 Scope: 1	0823	R1 has passed away even before we were able to apply for a waiver.	06/30/2025

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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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
0870 SS= E	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 paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication regimen review was completed every six months for 3 of 8 residents (Resident #5, #6, and #8). Findings include: Resident #5 (R5) R5 was admitted to the facility on 08/05/2024 with a diagnosis of End Stage Renal Disease (ESRD). Review of R5's file revealed no documented evidence a pharmacy review had been completed in the last 12 months. Resident #6 (R6) R6 was admitted to the facility on 02/18/2023 with a diagnosis of Dementia. R6's file documented a medication review last completed on 05/10/2024. Review of R6's file revealed no documented evidence a pharmacy review had been completed in the last 12 months. Resident #8 (R8) R8 was admitted to the facility on 11/19/2024 with a diagnosis of	0870	1. Administrator immediately requested medication reviews for the said employees. 2. Administrator made a check list of the requirements of the residents files. 3. Administrator will regularly check resident files for completion and compliance. 4. The administrator will make sure POC is implemented. 5. Completed on June 30, 2025 6. Please see attached copies of medication reviews.	06/30/2025

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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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
	Dementia. Review of R8's file revealed no documented evidence a pharmacy review had been completed in the last six months. On 05/29/2025 in the morning, the House Manager acknowledged the resident files lacked documented evidence of a medication review completed every six months. Severity: 2 Scope: 2			
0994 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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure the laundry room containing bleach was secured, and inaccessible to residents. Findings include: On 05/29/2025 at 9:36 AM, a bottle of bleach was observed in the laundry rooms which was not secured and was accessible to residents. On 05/29/2025 in the morning, the House Manager acknowledged the bottle of bleach was left unsecured in the laundry room, and the room should have been secured and inaccessible to residents. Severity : 2 Scope: 3	0994	1. Administrator conducted a meeting right after the survey and reiterated the importance of keeping toxic substances away from residents. Staff explained that the bottle was empty. Administrator still insisted that empty or not all bottles of toxic substances should be keep away from residents or should be thrown away if it's empty. 2. Administrator posted a signage stating "All toxic substances should be securely locked". 3. Administrator will regularly check if toxic substances are securely kept and not accessible to residents. 4. The administrator will make sure POC is implemented. 5. Completed on May 29, 2025. 6. Please see picture of posted signage.	05/29/2025

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 _____	**05/29/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW HOMECARE	**7036 PLEASANT VIEW AVE, LAS VEGAS, NEVADA ,89147**

(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
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 record review and interview, the facility failed to ensure 3 of 4 employees received infection control training through a nationally recognized course (Employees #2, #3, and #4). Findings include: The following employee records lacked documented evidence infection control training was completed through a nationally recognized course: Employee #2 was hired on 10/02/2024, as a Caregiver. Employee #3 was hired on 10/02/2024, as a Caregiver. Employee #4 was hired on 04/01/2021, as a Caregiver. On 05/29/2025 in the morning, the House Manager acknowledged Employees #2, #3, and #4 did not receive infection control training through a nationally recognized course. Severity: 2 Scope: 3	1840	1. Administrator immediately instructed said employees to create an account with CDC Train and complete required trainings. 2. Administrator made a list of the required Infection Control Trainings for future reference. 3. Administrator will regularly check employee files for completion and compliance. 4. The administrator will make sure POC is completed. 5. Completed on June 30, 2025. 6. Please see attached copies of training certificates.	06/30/2025