Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9600	A. BUILDING _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND, LLC	**4354 E HARMON AVE, LAS VEGAS, NEVADA ,89121**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 05/15/24, 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 Alzheimer's disease, five Category I residents and five Category II residents. The census at the time of the survey was eight. Eight resident files and seven employee files were reviewed. The facility received a grade of B. 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 deficiencies were identified:	0000		

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 REPRESENTATIVE'S SIGNATURE Name: TRINA M ANDERSON Title: Administrator Date: 07/04/2025

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0936 SS= E	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 8 residents received a two-step tuberculosis (TB) test and/or an annual TB test (Resident #2, #3 and #5). Findings include: Resident #2 (R2) R2 was admitted on 02/19/25, with senile degeneration of the brain. R2's file revealed a one-step TB test on 02/22/25. R2's file lacked documented evidence of a second-step TB test. Resident #3 (R3) R3 was admitted on 07/02/24, with diagnosis including edema. R3's file revealed a negative QunatiFERON blood test on 09/12/23. R3's file lacked documented evidence of an annual TB test for 2024. Resident #5 (R5) R5 was admitted on 09/03/24, with diagnosis including developmental delay. R5's file revealed a one-step TB test on 08/26/24. R5's file lacked documented evidence of a second-step TB test. On 05/22/25 in the afternoon, the Administrator acknowledged the missing TB tests and was unable to provide the documentation. Severity: 2 Scope: 2 On 05/22/25 in the afternoon, the Administrator confirmed person-centered service plans were not developed for the residents.	0936	1) The TB test was completed for resident #2 for the two step and the QuantiFERON was found for the resident and one resident is not due until August 2025. 2) Administrator or Designee will follow the tracker to ensure that the residents get their TB test in a timely manner. 3) A tracker will help monitor all residents due dates on their TB tests. Administrator or Designee will check monthly. 4) Administrator or Designee 5) 6/12/25	06/12/2025

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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 a door leading to the outside was equipped with an audible alarm. Findings include: On 05/22/25 in the morning, the back door alarm leading to the outside was turned off. On 05/22/25 in the morning, the Caregiver acknowledged the door alarm was turned off and should have remained on to alert staff when the door was opened. Severity: 2 Scope: 3	0991	1) The group home turned the alarm on and installed new battery. 2) Alarm will remain on. A note has been put on the door to remind the staff to keep the alarm on at all times. New batteries will be replaced when needed. 3) Lead Caregiver will ensure that the door alarm is on daily. 4) Administrator or Designee 5) 5/22/25	05/22/2025
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 an annual tuberculosis (TB) test was completed for 1 of 7 employees (Employee #6). Findings include: Employee #6 (E6) E6 was hired on 10/04/24, as a Caregiver. E6's file revealed a two-step TB test completed on 03/25/24. E6's file lacked documented evidence of an annual TB test for 2025. On 05/22/25 in the afternoon, the Administrator acknowledged the missing documentation and was unable to provide the annual TB test. Severity: 2 Scope: 1	0102	1) TB test was in the employees file under the wrong tab. Group home will ensure that all TB's are done in a timely manner. 2) A tracker will be used to ensure that the employees get their TB test including their annual in a timely manner. 3) Administrator or Designee will check monthly. 4) Administrator or Designee 5) 5/22/25	05/22/2025

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0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted on 02/28/24, with diagnosis including diabetes. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted on 02/19/25, with senile degeneration of the brain. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted on 07/02/24, with diagnosis including edema. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted on 10/03/23, with diagnosis including chronic kidney disease. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted on 09/03/24, with diagnosis including developmental delay. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted on 08/21/24, with diagnosis including altered mental status. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted on 11/12/24, with diagnosis including dementia. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted on 03/02/24, with diagnosis including anoxic brain damage. R8's file lacked a person-centered service plan. On 05/22/25 in the afternoon, the Administrator confirmed person-centered service plans were not developed for the residents. Severity: 2 Scope: 3	0515	1) The group home completed a Person Service Care Plan for each resident that needed one. 2) The Person Center Service Care Plan will be part of the move in packet for to be completed before move in. 3) Administrator or Designee will review the move in paperwork to ensure complete. 4) Administrator or Designee 5) 6/09/25	06/09/2025
0870	Medication Administration-Accuracy &	0870	1) The group home completed the	07/03/202

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SS= F	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 interview and record review, the facility failed to ensure a medication review, was completed every six months, for 7 of 8 residents (Resident #1, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted on 02/28/24, with diagnosis including diabetes. R1's file revealed the past two six month medication reviews were not completed. Resident #3 (R3) R3 was admitted on 07/02/24, with diagnosis including edema. R3's file revealed a six month medication review was not completed. Resident #4 (R4) R4 was admitted on 10/03/23, with diagnosis including chronic kidney disease. R4's file revealed the past two six month medication reviews were not completed. Resident #5 (R5) R5 was admitted on 09/03/24, with diagnosis including developmental delay. R5's file revealed a six month medication review was not completed. Resident #6 (R6) R6 was admitted on 08/21/24, with diagnosis including altered mental status. R6's file revealed a six month medication review was not completed. Resident #7 (R7)		Medication Reviews for each resident that was still remaining at the group home that needed one. Sent to the hospice, Pharmacy or physician to be signed. Resident #1, 2, and #8 have moved out since the audit. 2) Med Reviews will be done every 6 months 3) Administrator or Designee will complete the medication form and the Lead Caregiver will fax to the hospice companies, pharmacies or physician to review and sign. 4) Administrator or Designee 5) 7/3/25	5

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	R7 was admitted on 11/12/24, with diagnosis including dementia. R7's file revealed a six month medication review was not completed. Resident #8 (R8) R8 was admitted on 03/02/24, with diagnosis including anoxic brain damage. R8's file revealed the past two six month medication reviews were not completed. On 05/22/25 in the afternoon, the Administrator acknowledged the missing medication reviews and was unable to provide the documentation. Severity: 2 Scope: 3			