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 _____	**06/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CIRCLE OF CARE-ACKERMAN LLC	**7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and Complaint Investigation survey, completed at your facility on 06/30/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 beds for elderly and disabled persons and/or persons with Alzheimer Disease, Category II residents. The census at the time of survey was nine. Ten resident files and four employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Substantiated without deficiencies. Complaint #NV00074189 was substantiated with no deficient practice. The investigation of the complaint included: Observation of residents personnel property and staff/resident interactions. Interviews were conducted with residents, Caregivers and the Administrator. Clinical Record Review of ten records, which included the resident of concern. Document review which included facility policies and procedures, incident reports and employee records. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: FRANCESCA SLACEDO | Title: Administrator | Date: 07/16/2025

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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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 interview and record review, the facility failed to develop a person-centered service plan for 6 of 9 residents (Resident #1, #3, #5, #6, #8 and #9). Findings include: Resident #1 (R1) R1 was admitted on 03/09/25 with diagnosis including type 2 diabetes mellitus. R1's file lacked a completed person-centered service plan. Resident #3 (R3) R3 was admitted on 03/19/24 with diagnosis including Alzheimer's disease. R3's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted on 02/16/23 with diagnosis including heart failure. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted on 01/22/18 with diagnosis including chronic heart failure and dementia. R6's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted on 11/01/24 with diagnosis including dementia. R8's file lacked a person-centered service plan. Resident #9 (R9) R9 was admitted on 06/01/24 with diagnosis including cellulitis. R9's file lacked a person-centered service plan. On 02/21/24 in the afternoon, the Administrator confirmed person-centered service plans were not developed for R1, R3, R5, R6, R8 and R9. Severity: 2 Scope: 3	0515	A. The Administrator immediately made the Person Centered Service Plan for the Residents mentioned in the SOD. B. The Administrator from hereon shall ensure that a Person Centered Service Plan are made upon admission of Residents. Staff are also enjoin to ensure that a Person Centered Service Plan is done and in the files each Resident. C. Accomplished June 30, 2025	06/30/2025

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on interview and record review, the facility failed to ensure a physical exam was completed, upon admission, for 1 of 9 residents (Resident #3) and annually for 1 of 9 residents (Resident #5). Findings include: Resident #3 (R3) R3 was admitted on 03/19/24 with diagnosis including Alzheimer's disease. Review of R3's medical record revealed R3 had not had a physical exam since being admitted to the facility. Resident #5 (R5) R5 was admitted on 02/16/23 with diagnosis including heart failure. Review of R5's medical record revealed R5 last completed a physical exam on 02/16/24. There was no documentation an annual physical exam was completed for R5. On 06/30/25, in the morning, the Administrator was unable to provide documentation of an initial physical exam for R3 and an annual physical exam for R5. Severity: 2 Scope: 1	0859	A. The Administrator immediately requested for a Physical Assessment/Examination Order for new Admission of Residents mentioned in the SOD. A Plan dated May 15, 2025 was provided made by an NP to the facility. B. The Administrator from hereon shall ensure that a Physical Assessment/Examination Order for new Admission are made upon admission of Residents. Staff are also enjoin to ensure that a Physical Assessment/Examination Order for new Admission is done and in the files each Resident. C. Accomplished June 30, 2025	06/30/2025

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0870 SS= D	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 interview and record review, the facility failed to ensure a medication review, was completed every six months, for 1 of 9 residents (Resident #9). Findings include: Resident #9 (R9) was admitted on 06/01/24 with a diagnosis of cellulitis. Review of R9's record revealed a six month medication review had not been completed for R9. On 06/30/25 in the morning, the Administrator confirmed a six month medication review had not been completed for R9. Severity: 2 Scope: 1	0870	A. The Administrator immediately requested for Medication Review of the Resident mentioned in the SOD. Medication Reviews were made dated December 01, 2024 and June 30, 2025 were provided made by an RN to the facility. B. The Administrator from hereon shall ensure that a Medication Review is made every six months for each Residents. Staff are also enjoin to ensure that the six month Medication Review is done and in the files each Resident. C. Accomplished June 30, 2025	06/30/2025

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on interview and record review, the facility failed to ensure range orders were not in use for 1 of 8 residents (Resident #6) Findings include: Resident #6 (R6) was admitted on 01/22/18 with diagnosis including chronic heart failure and dementia. Review of R6's medical record revealed the following physician's order: -Order dated 12/28/24, Clonidine 0.1 milligram, take one tablet twice a day as needed for systolic blood pressure above 160. On 06/30/25, in the morning, the Administrator confirmed R6 had a range order on the medication Clonidine and range orders are not allowed. Severity: 2 Scope: 1	0876	A. The Administrator immediately contacted the Primary Care Physician of the Resident mentioned in the SOD within the day of the Annual Survey and been following it up every now and then to date. A Discontinue Order was just provided by the PCP to the facility today, July 16, 2025. B. The Administrator from hereon shall ensure that all Medication that needs to be discontinued shall have the Physician Order in the Resident's file. Staff are also enjoin to ensure that the Physician Order for discontinued medications are done and in the files each Resident. C. Accomplished July 16, 2025	07/16/2025
0938 SS= D	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	0938	A. The Administrator immediately made the Activities of Daily Living (ADL) for the Residents mentioned in the SOD. B. The Administrator from hereon shall ensure that the Activities of Daily Living (ADL) are made upon admission of Residents and annually thereafter. Staff are also enjoin to ensure that the Activities of Daily Living (ADL) is done and in the files each Resident. C. Accomplished June 30, 2025	06/30/2025

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	limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed upon admission, for 1 of 9 residents (Resident #8) and annually for 1 of 9 residents (Resident #6). Findings include: Resident #6 (R6) R6 was admitted on 01/22/18 with diagnosis including chronic heart failure and dementia. Review of R6's medical record revealed R6 last completed an ADL assessment on 01/28/24. There was no documentation an ADL assessment was completed in the past 12 months for R6. Resident #8 (R8). R8 was admitted on 05/10/25 with diagnosis including dementia. Review of R8's medical record revealed an ADL assessment was not completed upon admission for R8. On 06/30/25, in the morning, the Administrator was unable to provide documentation of completion of an initial ADL for R8 or an annual ADL for R6. Severity: 2 Scope: 1			

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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 all doors, which exited the facility, had an audible alarm. Findings include: On 06/30/25, in the morning, a door, which led to the backyard, did not have a functional audible alarm when the door was opened. On 06/30/25, in the morning, a Caregiver confirmed a door, which led into the backyard, did not have an audible alarm because it was shut off. Severity: 2 Scope: 3	0991	A. The Administrator immediately discussed with the Staff within the day after the Annual Survey to inspect and ensure that all door alarms are on and operational. B. The Administrator from hereon shall routinely inspect each door alarms are on and operational. Staff are also enjoin to routinely inspect each door alarms and ensure that each are on and operational. C. Accomplished June 30, 2025	06/30/2025

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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 two drawers, which contained multiple knives, were properly locked and secured. Findings include: On 06/30/25 at 9:15 AM, a kitchen drawer, which contained multiple knives, was found unlocked and partially open. There were no staff observed in the kitchen at this time. On 06/30/25 at 11:00 AM, the same kitchen drawer, which contained multiple knives, remained unsecured and unlocked. There were no staff present in the area. On 06/30/25, at 11:15 AM, the Administrator confirmed a drawer with multiple knives in it, was not properly locked and secured. Severity: 2 Scope: 3	0994	A. The Administrator immediately discussed with the Staff within the day after the Annual Survey to ensure that all drawers containing sharp object are constantly locked every after use. B. The Administrator from hereon shall routinely inspect each drawers containing sharps are maintained locked every after use. Staff are also enjoin to ensure that each drawers containing sharps are maintained locked every after use.. C. Accomplished June 30, 2025	06/30/2025

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0999 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: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure cleaning supplies were locked up and inaccessible to residents. Findings include: On 06/30/25 at 10:00 AM, a bottle of Lysol cleaning solution, dish soup and hand soup were found in an unlocked cabinet under the sink, in the kitchen. On 06/30/25, in the morning, a bottle of bleach, multiple cleaning solutions, window cleaner, disinfecting wipes and sprayable air fresheners were found inside the laundry room, which was unsecured. On 06/30/25 in the morning, the Administrator confirmed multiple chemicals in both the kitchen and laundry room were unsecured and should be locked up. Severity: 2 Scope: 3	0999	A. The Administrator immediately discussed with the Staff within the day after the Annual Survey to ensure that all toxic chemicals are placed in a locked area every after use. B. The Administrator from hereon shall ensure that all toxic chemicals are placed in a locked area every after use Staff are also enjoin to ensure that all toxic chemicals are placed in a locked area every after use. C. Accomplished June 30, 2025	06/30/2025