STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10176	A. BUILDING _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HOME CARE RHL	975 CORDONE AVENUE, RENO, NEVADA ,89502

(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 State Licensure annual grading survey conducted at your facility on 08/14/2025, in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness 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 D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a re-survey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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. There following regulatory deficiencies were identified:	0000		
0870 SS= C	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,	0870	-The facility will make sure that when the six month medication review arrives it needs to be handed to the administrator ASAP for initials. -The facility will assign employee to monitor that all six month medication review is initialed or sign by the administrator within 72 hours so the deficient practice will not recur. -The facility administrator will make sure that the corrective action will be implemented. -See attachment.	07/12/2026

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	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 six-month medication reviews were reviewed and signed by the Administrator for 6 of 6 residents requiring a medication review (Residents #3, #4, #5, #6, #7, and #8). Findings include: Resident #3 was admitted to the facility on 02/08/2021, with a diagnosis of schizophrenia. Pharmacy medication review form dated 08/12/2024 and 02/15/2025, did not include the Administrator's signature or initials. Resident #4 was admitted to the facility on 03/23/2018, with a diagnosis of Atrial Fibrillation. Pharmacy medication review form dated 08/12/2024 and 02/15/2025, did not include the Administrator's signature or initials. Resident #5 was admitted to the facility on 05/25/2024, with a diagnosis of dementia. Pharmacy medication review form dated 08/12/2024 and 02/15/2025, did not include the Administrator's signature or initials. Resident #6 was admitted to the facility on 02/16/2024, with a diagnosis of arthritis. Pharmacy medication review form dated 08/12/2024 and 02/15/2025, did not include the Administrator's signature or initials. Resident #7 was admitted to the facility on 08/16/2024, with a diagnosis of bipolar disorder. Pharmacy medication review form dated 02/15/2025 and 08/01/2025, did not include the Administrator's signature or initials. Resident #8 was admitted to the facility on 09/26/2024, with a diagnosis of diabetes mellitus II. Pharmacy medication review form dated 02/15/2025, did not include the Administrator's signature or initials. On		Employee #5 is no longer with us.	

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	08/14/2025 at 5:30 PM, the Administrator confirmed the Administrator had not signed the last two medication reviews for Residents #3, #4, #5, #6, and #7 and did not sign the last medication review conducted for Resident #8. The facility did not have a policy related to medications including medication review. Severity: 1 Scope: 3			
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 pursuant to subsection 2 of NRS 449.0302	0960	The facility will make sure that resident #2 has acceptable physician placement determination to the group home. -The facility will make sure all new admission to the group home accompanies the right physician placement determination. -The facility will assign someone to monitor that all new admission has the right physician placement so that this deficient practice will not recur. -The facility administrator will make sure that this corrective action is implemented. See attachment.	07/12/2026

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	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 indicating the resident was in need of a facility endorsed for the care of persons with Alzheimer's disease/dementia was not retained for admission for 1 of 8 residents (Resident #2). This deficient practice had the potential to result in the resident becoming harmed or harming another individual. Findings include: Resident #2 Resident #2 was admitted to the facility on 07/23/2025, with a diagnosis of dementia. Resident #2's clinical record included a Physician Placement Determination assessment dated 07/29/2025, indicating the resident required a facility endorsed for the care of residents with Alzheimer's disease or related dementia, because the resident suffered from dementia to the extent the resident was a danger to themselves or others if the resident was not placed in a secure unit or facility. The facility's license lacked documentation of Alzheimer's and dementia endorsement. On 08/14/2025 at 4:58 PM, the Administrator verbalized the resident's dementia appeared very mild to the Administrator, and the Administrator did not feel the resident should have a diagnosis of Alzheimer's disease. The Administrator confirmed the facility did not have Alzheimer's and dementia endorsement. Severity: 2 Scope: 1			
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed and any employee	1300	-The facility will make sure that the NON DISCRIMINATION POLICY is always posted in area where you can easily see it. -The facility will assign someone to monitor that NON DISCRIMINATION POLICY is always posted in area where everybody can see it to ensure this deficiency will not happen again. -The administrator of the facility will make sure this corrective action will be	07/12/2026

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	or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to		implemented. Please see attachment	

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	be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments: Based on observation, document review, and interview, the Administrator failed to post a non-discrimination statement in a prominent place within the facility per state regulations. Findings include: On 08/14/2025 at 9:05 AM, a current version of the non-discrimination statement was not displayed in the facility in a prominent area as required. On 08/14/2025 at 10:25 AM, the Administrator confirmed a current version of the State's non-discrimination statement had not been posted in a prominent area of the facility. The Administrator confirmed the facility did not have a discrimination policy. Severity: 1 Scope: 3			
1540 SS= F	Cultural Competency Training - R004-24 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single	1540	-The facility will make sure that CULTURAL COMPETENCY TRAINING is updated every 2 years by all caregivers. -The facility will assign employee to monitor that CULTURAL COMPETENCY TRAINING are updated by all caregivers in timely manner. -The facility administrator will make sure that corrective measure is implemented correctly.Employee #6 was no longer with us and employee #7 is not our employee.Please see attachment -The facility will make sure that employee #1, employee #2, employee #3,employee #4,employee #5 has updated cultural competency training. -	07/12/2026

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	instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency (CC) training was completed biennially for 5 of 6 sampled employees required to obtain cultural competency training (Employee #1, Employee #2, #3, #4, and #5). Findings include: The following employees lacked documented evidence cultural competency training was completed biennially. Employee #1 Employee #1 was hired by the facility as the Administrator with a start date of 01/09/2009. On 08/14/2025, Employee #1's personnel file contained a cultural competency training certificate dated			

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	01/28/2023. Employee #1 ' s personnel file lacked documented evidence cultural competency training was completed after 01/28/2025. Employee #2 Employee #2 was hired by the facility as a Caregiver with a start date of 03/24/2009. On 08/14/2025, Employee #2's personnel file contained a cultural competency training certificate dated 01/28/2023. Employee #2's personnel file lacked documented evidence cultural competency training was completed after 01/28/2023. Employee #3 Employee #3 was hired by the facility as a Caregiver with a start date of 04/20/2013. On 08/14/2025, Employee #3's personnel file contained a cultural competency training certificate dated 08/06/2022. Employee #3's personnel file lacked documented evidence cultural competency training was completed after 08/06/2022. Employee #3's personnel record documented CC training was last completed on 08/06/2022 and lacked documentation the training was completed on or before 08/06/2024 and did not document the training was completed at any time after 08/06/2024. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 06/28/2023. On 08/14/2025, Employee #4's personnel file contained a cultural competency training certificate dated 05/04/2024. Employee #4' s personnel file lacked documented evidence cultural competency training was completed after 05/04/2024. Employee #5 Employee #5 was hired by the facility as a Caregiver with a start date of 07/16/2024. On 08/14/2025, Employee #5's personnel file contained a cultural competency training certificate dated 07/12/2024. Employee #4's personnel file lacked documented evidence cultural competency training was completed after 07/12/2024. On 08/14/2025, at 11:38 AM, the Administrator confirmed Employee #1, #2, #3, #4, and #5 had not completed the required biennial cultural competency training. Severity: 2 Scope: 3			
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS	1600	-The facility will make sure resident #3, #5, #6, #7, #8 will have in their file the records that reflects their preferred name, pronoun, gender identity or expression, and sexual orientation. -The facility will assign employee to monitor	07/11/2026

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	449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure there were policies developed and resident records were in compliance with R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 5 out of 8 residents residing at the facility (Resident #3, #5, #6,		that all residents will have records that reflects their preferred name, pronoun, gender identity or expression, and sexual orientation so that this deficient practice will not happened again. The facility administrator will see to it that the corrective action is followed. Please see the attachment. -Employee #5 is no longer with the facility.	

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	#7, and #8). Findings include: Resident #3 was admitted to the facility on 02/08/2021, with a diagnosis of schizophrenia. Resident #5 was admitted to the facility on 05/25/2024, with a diagnosis of dementia. Resident #6 was admitted to the facility on 02/16/2024, with a diagnosis of arthritis. Resident #7 was admitted to the facility on 08/16/2024, with a diagnosis of bipolar disorder. Resident #8 was admitted to the facility on 09/26/2024, with a diagnosis of diabetes mellitus II. On 08/14/2025 at 5:30 PM, the clinical records for Resident #3, #5, #6, #7, and #8 did not include documentation of the residents' preferred name, pronouns, gender identity or expression, and/or sexual orientation and was not in compliance with R016-20 Section 19. On 08/14/2025 at 5:35 PM, the Administrator confirmed the clinical records for Resident #3, #5, #6, #7, and #8 did not include documentation of the residents' preferred name, pronouns, gender identity or expression, and/or sexual orientation and was not in compliance with R016-20 Section 19. The Administrator confirmed the facility did not have a policy related to discrimination. Severity: 1 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - 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. 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	1700	-The facility will make sure that before residents are admitted to the Group home they have the correct physician placement determination. -The facility will assign someone to monitor that all admissions will accompany the correct physician placement determination so that this deficient practice will not happen again. -The facility administrator will make sure that this corrective measure is being followed.	07/10/2026

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	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 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 clinical record review and interview, the Administrator failed to ensure an initial Physician Placement Determination was completed prior to admitting a resident to the facility for 1 of 8 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 07/23/2025, with diagnoses including dementia, chronic obstructive pulmonary disease, chronic kidney disease stage IV, and hypertension. Resident #2's clinical record included an initial Physician Placement Determination form signed and dated by a physician on 07/29/2025, six days after the resident was admitted to the facility. On 08/14/2025 at 4:58 PM, the Administrator confirmed Resident #2's clinical record lacked an initial physician placement determination completed prior to the resident being admitted to the facility. Severity: 2 Scope: 1			

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, record review, personnel record review, document review, and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAGs Y0102, Y0104, Y0106, Y0174, Y0178, Y0515, Y1540, Y1300, and Y1600. Severity: 2 Scope: 3	0050	-The facility will make sure that Tags y0102,y0104,y0106,y0174,y0178,y0515,y1540,y1300,y1600 are address and answered correctly. -The facility will make sure the administrator will provide oversight and direction to the employees so they can also provide the necessary service and supervision to the residents. -The facility will also assign someone to help monitor that this deficient practice will not recur. -Ultimately the facility administrator should provide oversight and direction of the group home.	07/10/2026
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or	0074	-The facility will make sure that training for elder abuse for employee #5 is updated in timely manner. -The facility will make sure that training for elder abuse for all caregivers are updated in timely manner annualy. -The facility will assign someone to monitor the elder abuse training done by all employees in timely manner. -The facility administrator will make sure that the corrective action is implemented.	07/10/2026

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	home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to			

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	the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review and interview, the Administrator failed to ensure 1 of 7 employees (Employee #5) completed elder abuse training annually. Findings include: Employee #5 Employee #5 was hired by the facility as a Caregiver on 07/16/2024. Employee #5's personnel file contained elder abuse training dated 07/11/2024 and 08/04/2025, 24 days late. On 08/14/2025 at 5:35 PM, the Administrator confirmed the training was late and acknowledged the training should have been completed no later than 07/11/2025. The Administrator verbalized the facility did not have policies related to employee training. Severity: 2 Scope: 1			
0100 SS= D	Personnel File - NAC 449.200 & R043-22 Personnel files. (NRS 449.0302) 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: (a) The name, address, telephone number and social security	0100		09/16/2026

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	number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee, including, without limitation: (1) Certificates of completion for all training completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the training or an outline of the training; (e) Evidence that the references supplied by the employee were checked by the residential facility. Inspector Comments: Based on observation, record review, and interview, the Administrator failed to ensure an employee (Employee #7) had an employee file, completed prior to beginning work at the facility. Findings include: On 08/14/2025 at 11:16 AM, Employee #7 arrived at the facility to assist the caregiver with facility task. The Administrator verbalized Employee #7 was employed by the facility as a handy man and confirmed Employee #7 assisted with tasks inside and outside of the facility and did have contact with residents. The Administrator was not sure of the employee's start date and verbalized Employee #7 had been working at the facility for "a few months." On 08/14/2025, the Administrator explained the Administrator believed it was not necessary to have an employee file for Employee #7 because the employee was not a caregiver. The Administrator confirmed Employee #7 did not have an employee file including the following elements: -Employee #7's address, telephone number and social security number, -The date on which Employee #7 began employment at the facility, -Fingerprint and background check results, -a physical exam and a two-step tuberculosis screening test, and -documentation of training completed by Employee #7. The facility did not have a policy related to employee records. Severity: 1 Scope: 2		Employee #7 is no longer working for the facility and cannot be located. The facility did not have a signed contract with Employee #7. To correct the deficiency and prevent recurrence, the facility will ensure that any individual hired directly by the facility is treated as an employee and that all required personnel documentation is completed and maintained before the individual is permitted to work or have contact with residents. If an individual is provided through a contracted company, the facility will maintain a signed contract with the company and verify that all applicable requirements are met before the individual has contact with residents. The Administrator will review the personnel files and applicable contractor documentation for all current workers to identify any other areas that may be affected by the same deficient practice. Any deficiencies identified will be corrected. Going forward, the Administrator will verify required documentation before an individual begins work and will periodically audit personnel and contractor records to ensure continued compliance.	

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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 personnel record review and interview, the Administrator failed to ensure an initial two-step tuberculosis screening was completed for 1 of 7 employees (Employee #7), pursuant to Nevada Administrative Code, Chapter 441A. Findings include: Employee #7 Employee #7 was hired by the facility as a Handyman on an unknown date. A document titled "Screening for Tuberculosis Skin Test" (TST) dated 12/14/2024, documented Employee #7 had a TST placed on 12/11/2024, and read on 12/14/2024. The facility had unable to provide documented evidence a two-step TST was completed for Employee #7. On 08/14/2025 at 5:35 PM, the Administrator explained Employee #7 did not have an employee file and confirmed the Administrator did not ensure a two-step TST was completed for Employee #7. The facility did not have a policy related to employee work requirements. Severity: 1 Scope: 2	0102	Employee #7 is no longer working for Family Home Care and we are unable to locate him. Because he is no longer working for us and cannot be located, we are unable to obtain the missing TB documentation. We also did not have a signed contract with him. Going forward, we will make sure that anyone we hire who will have contact with our residents has the required background check and physical examination, including the required TB screening, completed and documented before they are allowed to have contact with residents. The Administrator will review our current employees to make sure everyone has the required TB screening, physical examination, and background check on file. Any missing or expired documentation found during the review will be corrected. The Administrator will also check these requirements for new employees before they are allowed to have contact with residents.	09/16/2026
0106 SS= F	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the Administrator failed to ensure 4 of 7 employees (Employee #1, # 2, 6, and #7) completed Cardiopulmonary Resuscitation (CPR) training upon hire and/or bi-annually. This deficient practice had the potential to result in residents not receiving the appropriate lifesaving care when needed. Findings include: Employee #5 Employee #5 was hired by the facility as a Caregiver on	0106	The employees mentioned in this deficiency are no longer working at the facility. We were not able to obtain their CPR cards during the time they worked for us. Going forward, we will make sure all required employees have current CPR/First Aid training and a copy of their CPR/First Aid card in their personnel file. New employees will have their required CPR/First Aid training completed before they start working with residents. The Administrator will keep track of the expiration dates and check them monthly so employees can renew their CPR/First Aid before it expires. Once renewed, a copy of the new card will be placed in their personnel file.	09/16/2026

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	07/16/2024 Employee #5's personnel file contained elder abuse training dated 07/11/2024 and 08/04/2025, 24 days late. Employee #1 Employee #1 was hired by the facility as an Administrator on 01/09/2009. Employee #1's personnel file contained CPR/First Aid training completed on 01/03/2023 and expired on 01/03/2025. Employee #1's employee file included documentation a CPR/First Aid course was completed on 01/28/2025. The course was completed 25 days after the expiration of Employee #1's previous CPR/ First Aid Course. Employee #2 Employee #2 was hired by the facility as a Caregiver on 03/24/2009. Employee #2's personnel file contained CPR/First Aid training completed on 01/03/2023 and expired on 01/03/2025. Employee #2's personnel file contained CPR/First Aid training completed on 01/28/2025. The course was completed 25 days after the expiration of Employee #2's previous CPR/ First Aid Course. Employee #6 Employee #6 was hired by the facility as a Caregiver on 06/10/2025. Employee #6's personnel contained CPR/First Aid training completed on 07/29/2025, 49 days after beginning work at the facility. Employee #7 Employee #7 was hired by the facility as a Handyman on an unknown date. Employee #7 did not have a personnel file, including documentation a CPR/First Aid Course had been completed. Employee #7 actual start date could not be provided by the facility due to the employee did not have an employee file. The Administrator verbalized Employee #7 had worked at the facility for "a few months." On 08/14/2025 at 5:35 PM, the Administrator confirmed Employee #1 and #2's CPR/First Aid course was completed late and acknowledged the courses should have been completed on or before 01/03/2025. The Administrator confirmed Employee #6 had not completed a CPR/First Aid course prior to beginning work at the facility, and confirmed Employee #7 had not completed a CPR/First Aid course prior to or at any time after beginning to work at the facility. The facility did not have a policy related to CPR and/or First Aid training. Severity: 2 Scope: 3		We also reviewed the files of our current employees to make sure their CPR/First Aid training is current and their cards are in their files. The Administrator will be responsible for making sure this is followed going forward.	

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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the Administrator failed to ensure a pantry containing resident food remained free of rodents and the premises remained free of clutter and/or tripping hazards. This deficient practice had the potential to contaminate food ingested by all eight of the facility's residents and cause the residents to become ill with potentially life-threatening illnesses, such as Hantavirus. Findings include: On 08/14/2025 at 10:09 AM, numerous brown pellets with the appearance of mouse droppings were on top of cans of food and boxes of dry goods in the resident food pantry. On 08/14/2025 at 10:18 AM, the Administrator confirmed the pantry contained resident food and confirmed there were mouse droppings on the shelves and on top of cans and boxes of food in the pantry and verbalized the pantry should have been cleaned. The Administrator confirmed the facility did not have a policy related to pest control and/or food storage. Severity: 2 Scope: 3	0174	-The facility will make sure the pantry is free and clear of rodents. -The facility will make sure the whole facility is free from rodents. -The facility will make sure that pest control company is always hired to avoid presence of rodents and other pest around the facility. -The facility administrator will make sure this corrective action is being implemented so it will not happen again. See attachment	07/12/2026
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the side yard and back yard were free of refuse, tripping hazards and stored items. This deficient practice had the potential to attract unwanted pest and placed residents at risk of illness, tripping and/or becoming injured. Findings include: On 08/14/2025 at	0178	-The facility will make sure that the facility are free from refuse, tripping hazards, around the house. -The facility will make sure that the vehicle park at the driveway is remove. -The facility will make sure that tripping hazards, stored garbage, refuse and old vehicles are remove from the facility. -The facility will assign someone to monitor this deficient practices so they will not happen again. -The facility administrator will see to it that this corrective action is being implemented. See attachment.	07/12/2026

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	9:15 AM, a vehicle was parked in the facility's front driveway, the wheels had been removed, and the vehicle was placed on cinder blocks. On 08/14/2025 at 11:06 AM, the following items were located on the side of the facility, next to a resident patio: -a bag of clothes, -a plastic cart containing numerous compact discs (CD's), -a cart containing miscellaneous tools, -one skateboard, -one tarp, -a bucket containing a brush and several brackets, -extension cords, and -a table saw. On 08/14/2025 at 11:07 AM, a long hose was draped across the patio next to a covered visiting area utilized by residents. On 08/14/2025 at 11:08 AM, the following items were located next to the back of the house near the sprinkler shut off. -two dollies -two brooms -a basket -a plastic bag containing a used air fryer, and -an oxygen tank in a single canister cart. On 08/14/2025 at 11:07 AM, the Administrator confirmed the items on the side of the house should have been removed from the area. The Administrator confirmed the hose should have been put away and was a tripping hazard. On 08/14/2025 at 11:08 AM, the Administrator verbalized the car in the front drive belonged to the facility's handyman and had been in the drive on blocks for about one month. The Administrator verbalized the oxygen tank belonged to a deceased resident. The Administrator explained the Administrator believed the oxygen tank was out of "gas" when asked if it was safe and acceptable to store the oxygen tank outdoors. The Administrator declined to confirm if the tank should or should not have been stored outside. On 08/14/2025 at 11:16 AM, the Handyman verbalized the car in the front driveway had broken down last winter and it had been too cold to fix the car. On 08/14/2025 at 11:46 AM, the Handyman verbalized the oxygen tank was not empty and had contained oxygen while being stored in the backyard and explained the Handyman had since "drained" the tank. The facility did not have a policy related to pest control and did not have a policy related to safely maintaining the premises. Severity: 2 Scope: 3			

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0252 SS= F	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation and interview, the Administrator failed to ensure food was properly packaged and stored. This deficient practice had the potential to result in the facility's census of eight residents becoming sick with food borne illness related to cross contamination and improper food storage practices. Findings include: On 08/14/2025 at 12:15 PM, two pieces of raw bacon were found inside an unsealed hotdog package in the facility's freezer, and two sausage links and one hotdog bun were found in the oven. The Administrator Designee explained the sausage and hotdog bun had been placed in the oven until they could be thrown away at a later time. On 08/14/2025 at 12:15 PM, the Administrator Designee confirmed the bacon should not have been stored in the hotdog package and the package should not have been left unsealed. The Administrator Designee confirmed the sausage and hotdog bun located in the oven should have been thrown away and not placed in the oven. The facility did not have a policy related to food storage. Severity: 2 Scope: 3	0252	-The facility will make sure that all food stored in the freezer and fridge are labelled with unexpired date. -The facility will make sure that leftover food are not stored in the oven. -The facility will assign someone to monitor that this deficient practice will not happen again. -The facility administrator will make sure that this corrective action is being implemented.	07/13/2026

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0451 SS= F	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the Administrator failed to ensure the facility's first aid kit was stocked with the required items. This deficient practice had the potential to result in residents receiving delayed or inadequate first aid measures when needed. Findings include: On 08/14/2025 at 12:18 PM, the facility's first aid kit did not include germicide, adhesive tape, or disposable gloves. On 08/14/2025 at 12:18 PM, the Administrator Designee confirmed the items were not included inside of the facility's first aid kit. Severity: 2 Scope: 3	0451	-The facility will make sure the 1st aid kit is complete and not expired. -The facility will make sure the group home has complete and unexpired 1st aid kit. -The facility will assign someone to monitor that 1st aid kit has complete package necessary needed for 1st aid. -The facility administrator will see to it that this corrective action is implemented.	07/13/2026
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 clinical record review and interview, the facility failed to develop a Person-Centered Service Plan addressing all required focus areas and interventions for 8 of 8 residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). This deficient practice had the potential to result in residents not receiving the necessary care and services placing the	0515	-The facility will make sure resident #1, resident #2,resident #3,resident #4,resident #6,resident #7 and resident #8 has Person-centered service plan.Resident #5 is no longer with us. -The facility will make sure that Person-centered service plan is develop to every resident annualy. -The facility administrator will make sure that this corrective action is implemented properly so it will not happen again.	07/11/2026

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	10176	A. BUILDING _____ B. WING _____	08/14/2025

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	residents at greater risk for injury, illness and emotional distress. Findings include: Resident #1 Resident #1 was admitted to the facility on 08/08/2025, with diagnoses including chronic obstructive pulmonary disease (COPD) and depression. Resident #2 Resident #2 was admitted to the facility on 07/23/2025, with diagnoses including COPD, dementia, chronic kidney disease, stage IV, and hypertension. Resident #3 Resident #3 was admitted to the facility on 02/08/2021, with a diagnoses including schizophrenia, essential tremors, and metabolic disorder. Resident #4 Resident #4 was admitted to the facility on 03/23/2018, with diagnoses including hypertension, atrial fibrillation, seizures, and stroke. Resident #5 Resident #5 was admitted to the facility on 05/25/2024, with diagnoses including dementia, hypertension, atrial fibrillation, and diabetes mellitus. Resident #6 Resident #6 was admitted to the facility on 02/16/2024, with diagnoses including arthritis, substance abuse disorder, chronic pain, and depression. Resident #7 Resident #7 was admitted to the facility on 08/16/2024, with diagnoses including bipolar disorder, COPD, and depression. Resident #8 Resident #8 was admitted to the facility on 09/26/2024, with diagnoses including diabetes mellitus II, hypertension, stroke, depression and anxiety. Residents #1, #2, #3, #4, #5, #6, #7, and #8 clinical records lacked documented evidence an initial and/or annual Person-Centered Service Plan had been complated. On 08/14/2025 at 2:16 PM, the Administrator confirmed the facility had not completed a Person-Centered Service Plan for any of the facility's eight residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). The Administrator confirmed the facility did not have a policy related to the development and implementation of Person-Centered Service Plans. Severity: 2 Scope: 3			
0530 SS= C	Activities for Residents - NAC 449.260 Activities for residents. (NRS 449.0302) 1. The caregivers employed by a residential facility shall: (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests	0530	-The facility well make sure that at least10 hours a week are spend for the residents activities. -The facility well make sure that time is indicated in the schedule so that the total time spent on the resident's activities	07/13/2026

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	and capacities; Inspector Comments: Based on observation and interview, the facility failed to provide at least 10 hours of scheduled weekly activities for 8 of 8 residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/08/2025, with diagnoses including chronic obstructive pulmonary disease (COPD) and depression. Resident #2 Resident #2 was admitted to the facility on 07/23/2025, with diagnoses including COPD, dementia, chronic kidney disease, stage IV, and hypertension. Resident #3 Resident #3 was admitted to the facility on 02/08/2021, with a diagnoses including schizophrenia, essential tremors, and metabolic disorder. Resident #4 Resident #4 was admitted to the facility on 03/23/2018, with diagnoses including hypertension, atrial fibrillation, seizures, and stroke. Resident #5 Resident #5 was admitted to the facility on 05/25/2024, with diagnoses including dementia, hypertension, atrial fibrillation, and diabetes mellitus. Resident #6 Resident #6 was admitted to the facility on 02/16/2024, with diagnoses including arthritis, substance abuse disorder, chronic pain, and depression. Resident #7 Resident #7 was admitted to the facility on 08/16/2024, with diagnoses including bipolar disorder, COPD, and depression. Resident #8 Resident #8 was admitted to the facility on 09/26/2024, with diagnoses including diabetes mellitus II, hypertension, stroke, depression and anxiety. On 08/14/2025 at 4:08 PM, the facility's Activity Calendar for July, August, and September 2025 included resident activities as follows: -Mondays: exercise/reading activities, -Tuesdays: taco Tuesday, -Wednesday: writing activities, -Thursday: board game night, -Friday: exercise/movie night -Saturday: backyard picnic, -Sunday: worship, rest. The Activities calendar did not document times for any of the activities, such as "board games" from 3:00 PM to 4:00 PM". Due to the lack of time frames it could not be determined how many hours of activities were provided for the residents each week. On 08/14/2025 at 4:12 PM, the		is at least 10 hours per week. -The facility will assign someone to monitor the deficient problem will not recur. -The facility administrator will see to it that this corrective action is implemented.Please see attachment.	

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	Administrator acknowledged meals such as taco Tuesday and backyard picnic, were being counted as activities on the Activity Calendar, however declined to confirm meals should not be used and/or counted as an activity. The facility did not have a policy related to resident activities. Severity: 1 Scope: 3			