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
	11041	A. BUILDING _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPENCER LUXURY CARE LLC	1951 PAPAGO LN, LAS VEGAS, NEVADA ,89169

(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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed at your facility on 06/29/2026. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II (Alzheimer's) residents. The census at the time of the survey was seven. Seven resident files and six employee files were reviewed. The facility received a grade of D.			

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Y 0102 SS= D	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on document review and interview, the facility failed to ensure an initial two-step tuberculosis (TB) test was completed for 1 of 6 employees (Employee #4). Findings include: Employee #4 (E4) E4 was hired on 03/31/2026 as a Caregiver. E4's file documented an initial 1-Step TB test dated 03/30/2026 with a negative result. E4's file lacked documented evidence of a completed initial 2-Step TB Skin test. On 06/29/2026 in the afternoon, the Administrator and E4 could not provide documentations of an initial 2-Step TB test. Severity: 2 Scope:1	Y 0102	Employee #4 had his TB Test 1 and 2 dated 6/29 and 7/1/26. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur.	08/26/2026

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Y 0104 SS= D	**NAC 449.200** **Personnel files** (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 6 employees complied with background check requirements per Nevada Revised Statutes (NRS) 449.123 (Employee #2 and Employee #4). Findings include: Employee #2 (E2) E2 was hired on 09/16/2024 as a Caregiver. E2's record lacked documented evidence of a Nevada Automated Background Check System (NABS) Clearance Letter. Employee #4 (E4) E4 was hired on 03/31/2026 as a Caregiver. E4's record lacked documented evidence of a NABS Clearance Letter. The Nevada Automated Background check system (NABS) system lacked documented evidence E2 and E4 had a completed background check for this facility. On 06/29/2026 in the morning, the Administrator could not provide documentations of NABS clearance letter for E2 and E4. Severity: 2 Scope: 1	Y 0104	Employees 2 and 4 have their background clearance dated 6/30/2026 and 4/20/2026. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur. Please see attached fingerprint of E2 and E4.	08/28/2026

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Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 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.	Y 0172	The entire facility, both inside and outside have been cleaned and are free from any hazards. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur.	08/26/2026

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	Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were clean and well maintained. Findings include: The following observations were made on 06/29/2026 in the morning: -An open lid cigarette can beside the backyard door. -A broken pipe extended from the roof to the backyard. -A hole with 6 planks and a carpet over it to the left side of the backyard. -An uncovered medical waste bin with used nitrile gloves inside to the left side of the backyard. -Two black paint cans next to the trash cans to the left side of the backyard. On 06/29/26 all residents had access to every part of the backyard. On 06/29/2026 in the morning, the Administrator and a Caregiver acknowledged the findings and should have been cleaned or repaired. Severity: 2 Scope: 3			
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working	Y 0250	All foods at the kitchen cabinet have been labeled and those that have expired have been thrown out. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur.	08/26/2026

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	condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 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. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation and interview, the facility failed to ensure food was properly labeled. Findings include: On 06/29/2026 in the morning, there were two bottles inside a kitchen cabinet with unidentified liquids, there were no labels indicating what was in the bottles, no package dates, and no throw away dates. On 06/29/2026 in the morning, the Administrator and a Caregiver confirmed there were miscellaneous food stored in old bottles which did not indicate what the item was, when it was stored, and when it needs to be removed or used by. Severity: 2 Scope: 3			
Y 0515 SS= D	NAC 449.259	Y 0515	Residents 2 and 7 have their PCP as of 6/29/26 and 6/23/26. Administrator will visit the facility weekly to ensure compliance and	08/26/2026

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	Supervision of residents. 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. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and		to conduct monthly meeting with the owners and employees so any deficiency does not recur. Please see attached PCP of 2 and 7.	

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	unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 7 residents had an initial and/or annual person-centered service plan (PCP) (Resident #2 and Resident #7). Findings include: Resident #2 (R2) R2 was admitted on 10/25/2024 with diagnoses including acute hypoxic respiratory failure with pneumonia, hypertension, chronic obstructive pulmonary disease, and hyperlipidemia. R2's file documented a PCP dated 05/23/2025. R2's file lacked documented evidence of an annual 2026 PCP. Resident #7 (R7) R7 was admitted on 10/22/2025 with diagnoses including hypertensive heart and kidney disease with chronic diastolic congestive heart failure and stage 2 chronic kidney disease, pulmonary hypertension, type 2 diabetes mellitus without complication, unspecified dementia with other behavioral disturbances. R7's file lacked documented evidence of an initial PCP. On 06/29/2026 in the morning, the Administrator was unable to provide documentations of an initial and/or annual PCP for R2 and R7. Severity: 2 Scope: 1			
Y 0878 SS= D	NAC 449.2742	Y 0878	Resident #5 medication, Triamcinolone Acetonide 0.1% cream was administered to the resident two times daily as instructed on the medication record dated 6/29 and	08/26/2026

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	5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered,		6/30/26. For those missed doses, physician is notified about it and told the owners to not worry about it but to advise the caregivers to be vigilant about it and not miss any doses.Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur. Please see attached note of owner.	

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	the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident received medications per the physicians' orders and failed to ensure a resident's record had documented evidence a physician was notified after a resident had missed medications for 1 of 7 sampled residents. (Resident #5) Findings include: Resident #5 (R5) R5 was admitted on 09/07/2023 with diagnoses including acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and muscle weakness. R5's medication bin contained Triamcinolone Acetonide 0.1% Cream, apply 1 gram topically to affected area(s) every morning and every night. A physician's order dated 04/28/2026 documented Triamcinolone Cream, 1 gram twice a day. Triamcinolone Acetonide 0.1% Cream was not recorded on R5's June 2026 Medication Administration Record (MAR). There was no documented evidence R5 was administered the Triamcinolone Acetonide 0.1% Cream. There was no discontinuation order for R5's Triamcinolone Acetonide 0.1% Cream. On 06/29/2026 in the afternoon, the Owner and a Caregiver acknowledged R5's Triamcinolone Acetonide 0.1% Cream was not administered per the physician's order. A Caregiver confirmed the facility had no documented evidence R5's physician			

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	was notified after the missed doses. Severity: 2 Scope: 1			
Y 0920 SS= F	NAC 449.2748 Medication Storage. 1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container	Y 0920	The medication found at the kitchen cabinet have been moved to a lock cabinet. Administrator have a meeting with the owners and employees to make sure that all medications be placed in a lock cabinet. Owners is responsible to see to it that this is followed through. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur. Please check attached pictures showing medication cabinet and cabinet for employees and cabinet for patients are locked.	08/26/2026

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	until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured and inaccessible to residents. Findings include: On 06/29/2026 in the morning, the medication cabinet located in the office was unlocked and opened with no staff member present, the office lacked a door and had a curtain in the doorway. All residents had access to the unsecured office where the medication cabinet was located. On 06/29/2026 in the morning, a Resident #5's bottle of Sucralfate 1 Gram (GM) /10 Milliliter (ML) Oral Suspension, take 5 ML by mouth in the morning and in the evening before meals was found in an unlocked cabinet in the kitchen right above the gate. On 06/29/2026 in the morning, a Caregiver acknowledged the medications were unsecured and should have locked the cabinet prior to answering the door. The Administrator acknowledged the bottle of Sucralfate was unsecured in the kitchen cabinet and should have been locked in the medication cabinet. Severity: 2 Scope: 3			

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Y 0991 SS= F	**NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personal required; training for employees.** (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 alarms were enabled on exit doors. Findings include: On 06/29/2026 in the morning, the alarm on the sliding glass door located in the living room, which led to the backyard, was turned off. On 06/29/2026 in the morning, a Caregiver acknowledged the alarm was turned off and should have been on. Severity: 2 Scope: 3	Y 0991	Alarms of both the front and back doors are always on. Administrator have a meeting with the owners and employees to make sure these alarms are not being turned off. Owners are responsible to see to it that this being followed. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur.	08/26/2026
Y 1540 SS= D	**NAC 449.011931and R004-24** NAC 449.011931 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;	Y 1540	Employee #2 had his certification of Cultural Competency training dated 6/29/26. Owners will be responsible to make sure all paperwork of employees are complete and current. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur.	08/26/2026

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SPENCER LUXURY CARE LLC	1951 PAPAGO LN, LAS VEGAS, NEVADA ,89169

(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
	(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 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 interview and documented review the facility failed to ensure cultural competency training was completed within 90 days of hire for 1 of 7 employees (Employee #2).			

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	Findings include: Employee #2 (E2) E2 was hired by the facility on 09/16/2024 as a Caregiver. E2's file lacked documented evidence of a E2 had completed cultural competency training within 90 days of being hired. On 06/29/2026 in the afternoon, the Administrator and E2 could not provide documentations E2 had completed cultural competency training within 90 days of hired. Severity: 2 Scope: 1			
Y 1700 SS= D	**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	Y 1700	Resident #4 have her Physician Placement Determination dated 4/22/26. Administrator instructed the owners and employees to make sure that all paperwork of residents are complete and recent. Administrator will check the records of employees and residents monthly. Administrator will monitor for compliance	08/14/2026

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	(c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the			

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	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 record review and interview, the facility failed to ensure an initial physician placement determination was obtained for 1 of 7 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 09/04/2025 with diagnoses including hypertension, hyperlipidemia, and dementia. R4's resident file lacked documented evidence of an initial physician placement determination. On 06/29/2026 in the morning, the Administrator was unable to provide documentation of an initial physician placement determination for R4. Severity: 2 Scope: 1			

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Y 1840 SS= D	**R063-21 Sec. 4.** 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 2 of 6 sampled employees completed the annual required infection control training for unlicensed caregivers (Employee #5 and #6). Findings include: Employee #5 (E5) E5 was hired on 12/04/2023 as a Co-owner. E5's file documented an infection control training dated 05/28/2025. E5's file lacked documented evidence of 2026 annual infection control training through a nationally recognized organization.	Y 1840	Both co-owners of the facility have their CDC Infection Control certification. Administrator have a meeting with the owners to make sure all paperwork is complete and current. Administrator will visit the facility weekly to ensure compliance and to conduct monthly meeting with the owners and employees so any deficiency does not recur. Please see attached all 15 CDC trainings.	08/26/2026

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	Employee #6 (E6) E6 was hired on 12/04/2023 as a Co-owner. E6's file documented an infection control training dated 04/08/2025. E3's file lacked documented evidence of 2026 annual infection control training through a nationally recognized organization. On 03/20/2026 in the morning, E5 and the Administrator acknowledged E5 and E6's missing infection control training and was unable to provide the documentation. Severity: 2 Scope: 1			