

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM			STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052	
(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 an annual and complaint investigation State Licensure survey completed at your facility on 06/27/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was nine. Nine resident files and four employee files were reviewed. The facility received a grade of B. There was one complaint investigated. Substantiated without deficient Practice: 1. Complaint #NV00071039 was substantiated with no deficient practice. The investigation of the Complaint included: Observation of resident medications and a tour of the facility. Interviews were conducted with residents and the Manager. Record Review of ten records, which included the resident of concern. Document Review included a full medication review and the Medication Administration Record. 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 Name: TIANA SOSA
REPRESENTATIVE'S SIGNATURE

Title: Manager

Date: 07/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2024	
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM				STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052			
(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	
0072 SS= D	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees received initial 16 hours of medication management training (Employee #3). Findings include: Employee #3 (E3) E3 was hired on 05/04/24 as a Caregiver. E3's file lacked documented evidence of initial 16 hours of medication management training. On 06/27/24 in the morning, E3 was the only Caregiver on duty and was not qualified to administer medications in the event a resident requested an as needed medication. On 06/27/24 in the morning, the Caregiver reported they were not trained in medication management. Severity: 2 Scope: 1	0072	1.Caregiver took the med tech class 2.Ensure there is a med tech on duty at all times 3.Manager will register caregivers who need med license if they do not have a license upon hiring 4.The Manager 5.July 4th 6.Med certificate uploaded			07/12/2024	

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2024	
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM				STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052			
(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	
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 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 or herself without supervision may keep the resident ' s medication in his or her 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. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were secured. Findings include: On 06/27/24 in the morning, the lock box in the refrigerator containing resident medications was unsecured. There was unsecured vitamins, cough medicine, and vapo rub in the Caregiver's room. On 06/27/24 in the morning, the Caregiver acknowledged the lock box and the Caregiver's room containing medications was unsecured and should have been locked. Severity: 2 Scope: 3	0920	1.Caregivers are required to keep any/all vitamins and meds in a lockbox when occupying caregiver room 2.A new lock has been placed on door and locks automatically when closing 3.House lead will ensure the door is closed at all times 4.The manager 5.July 4th 6.Picture of lock was submitted in email to surveyor and in POI			06/27/2024	

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2024	
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM				STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052			
(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		
0966 SS= F	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on observation and interview, the facility failed to ensure at least two Caregivers were available to provide care during the day for nine residents. Findings include: On 06/27/24 at 9:20 AM, the census of the facility was nine residents. There was one Caregiver on site upon arrival to the facility. The House Manager arrived approximately an hour after inspector's arrival. On 06/27/24 at 9:20 AM, the Caregiver reported night shift left at 8:00 AM and the other scheduled Caregiver called in sick. The Manager acknowledged there was nine residents to one Caregiver in the Manager's absence. Severity: 2 Scope: 3	0966	1.Manager will be sure to have 2 caregivers on shift 2.Scheduling enough caregivers and have a med tech cover if a callout occurs 3.By providing enough staff 4.The manager 5.July 4th		06/28/2024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2024	
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM				STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052			
(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		
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 sharp objects were not accessible to residents. Findings include: On 06/27/24 in the morning, the lock on the kitchen drawer was broken containing unsecured knives and there was one knife unsecured in the kitchen sink. On 06/27/24 in the morning, the Caregiver acknowledged the knives were unsecured and should have been locked. This was a repeat deficiency from the 01/18/23 and 06/29/23 State Licensure survey. Severity: 2 Scope: 3	0994	1.All sharps cabinet has a magnetic lock now,the broken lock has been replaced 2.To be sure any lock that is broken is replaced immediately 3.Staff is to check locks on a daily basis 4.House Lead 5.July 4th		06/27/2024		

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2024	
NAME OF PROVIDER OR SUPPLIER SRC ANTHEM				STREET ADDRESS, CITY, STATE, ZIP CODE 2269 PACINI COURT, HENDERSON, NEVADA ,89052			
(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		
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 toxic substances were not accessible to residents. Findings include: On 06/27/24 in the morning, the lock on the kitchen cabinet under the sink was broken containing unsecured dish detergent, multipurpose cleaner, scent booster, and bleach. On 06/27/24 in the morning, the Caregiver acknowledged the toxic substances were unsecured and should have been locked. This was a repeat deficiency from the 01/18/23, 03/10/23, and 06/29/23 State Licensure survey. Severity: 2 Scope: 3	0999	1.The cabinet that contained chemicals has been replaced 2.To ensure every chemical is in a locked cabinet 3.House lead is to check locks daily and be sure staff reports if any need to be replaced 4.House lead 5.July 4th		07/27/2024		