STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	354	A. BUILDING _____ B. WING _____	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACHELE SENIOR GUEST HOME	3398 BANCROFT CIRCLE, LAS VEGAS, NEVADA ,89121

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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 05/13/26. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons and/or individuals with mental illness, Category II residents. The census at the time of the survey was eight. Eight resident files and five employee files were reviewed. The facility received a grade of B.			

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Y 0102 SS= E	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 5 employees had an annual tuberculin (TB) test (Employees #2 and #5). Findings include: Employee #2 (E2) E2 was hired on 01/03/25 as a Caregiver. E2's file contained QuantiFERON Gold TB test results dated 07/03/24. E2's file lacked documented evidence of an annual TB test in 2025 or 2026. Employee #5 (E5) E5 was hired on 05/05/25 as a Caregiver. E5's file contained QuantiFERON Gold TB test results dated 05/15/25. E5's file lacked documented evidence of an annual TB test in 2026. On 05/13/26 in the afternoon, Employee #3 and Employee #5 acknowledged E2 and E5 had not received annual TB tests, as required. Severity: 2 Scope: 2	Y 0102	1) This finding will be corrected by conducting an updated tb test for E2 and E5. 2) To avoid deficiency recurrence, a quarterly employee file/folder review will be conducted to ensure documents are in compliance with the bureau. 3) The corrective action will be monitored by putting into calendar the dates such reviews should be conducted. 4) The person assigned to complete this task will be the facility administrator and/or a facility staff. 5) The corrective action was completed on May 20, 2026. 6) Refer to the attached file for proof of completion.	05/20/2026
Y 0104 SS= E	NAC 449.200 Personnel files (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive.	Y 0104	1) This deficiency will be corrected by immediately by processing the facility specific background check for E1 and E5. 2) A quarterly employee folder check/review will be conducted to ensure deficiency will not occur. 3) This corrective action will be monitored by setting a calendar reminder to review employee files/folders. 4) A group home staff and/or facility	06/08/2026

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	354	A. BUILDING _____ B. WING _____	05/13/2026

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	Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 5 Caregivers had completed background checks and Nevada Automated Background System results for this facility (Employees #1 and #5). Findings include: Employee #1 (E1) E1 was hired as a Caregiver on 09/20/25. E1's file documented a background check dated 01/14/26 and had a NABS clearance letter for another facility. E1's file lacked documented evidence of a background check conducted for this facility. An inquiry in NABS verified E1 was not on the facility roster. Employee #5 (E5) E5 was hired as a Caregiver on 05/05/25. E5's file documented fingerprints taken on 01/28/25, and had a NABS clearance letter for another facility. E5's file lacked documented evidence of a background check conducted for this facility. An inquiry in NABS verified E5 was not on the facility roster. On 05/16/26 in the afternoon, Employee #3 and Employee #5 acknowledged E1's and E5's background checks were not specific to this facility, and expressed they were not aware separate background checks for all facilities of employment were required by regulation. Severity: 2 Scope: 2		administrator shall conduct the employee folder/file review. 5) The required background check for E1 and E5 specific to the group home's location has been processed on June 8, 2026. 6) Refer to attached file for proof of finger printing.	
Y 0830 SS= D	**NAC 449.2736 and R089-24 Request to exempt certain resident from restrictions; contents of request.** 1. The administrator of a residential facility may submit to the Division a written request for permission to admit	Y 0830	1) The finding will be corrected by applying for the necessary waiver for R5. 2) To avoid/eliminate this deficiency recurrence, a quarterly resident folder/file review will be implemented to confirm that documents are in compliance with the bureau's requirements. 3) For the consistency of the corrective	08/05/2026

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	or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. 2. A written request submitted pursuant to this section must include, without limitation: (a) Records concerning the resident's current medical condition, including updated medical reports, other documentation of current health, a prognosis and the expected duration of the condition; (b) A plan for ensuring that the resident's medical need scan be met by the facility; (c) A plan for ensuring that the level of care provided to the other residents of the facility will not suffer as a result of the admission or retention of the resident who is the subject of the request; and (d) A statement signed by the administrator of the facility that the needs of the resident who is the subject of the written request will be met by the caregivers employed by the facility. 3. A written request submitted to the Division pursuant to this section must be received: (a) Before the administrator admits a resident; or (b) At the onset of a medical condition set forth in paragraph (a) or (i) of subsection 4 of NAC 449.2702. 4. The plan for ensuring that the medical needs of a resident who is bedfast can be		action, it will be monitored by setting a quarterly reminder via calendar regarding resident file/folder review. 4) The administrator and/or a facility staff shall conduct and oversee this corrective action. 5) A new and updated waiver has been applied for R5. Awaiting the result of the waiver application. A face sheet from R5's hospice provider is attached to indicate she no longer has a nephrostomy tube. 6) Please refer to attached file for summary of waiver application and R5's hospice face sheet.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACHELE SENIOR GUEST HOME	3398 BANCROFT CIRCLE, LAS VEGAS, NEVADA ,89121

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	met by the facility submitted pursuant to paragraph (b) of subsection 2 must include, without limitation: (a) An assessment of the needs of the resident made within 48 hours after admission to the residential facility or the time when the resident becomes bedfast, as applicable; (b) Measures to reduce the risk of blood clots and muscle atrophy; (c) Measures to decrease the development of pneumonia and other respiratory complications; (d) Measures to decrease constipation and other problems with bowel function; (e) Measures to meet the psychosocial needs of the resident, including, without limitation, planning activities in which the resident can participate such as listening to music, visitation and having another person read to the resident; (f) Measures to reduce injury, including, without limitation, pressure ulcers, foot drop, contractures and other related injuries; (g) Measures to ensure the nutritional needs of the resident are met and are provided in a safe manner to avoid problems such as aspiration; and (h) Measures to ensure the safe administration of medications. 5. Except as otherwise provided in subsection 6 and NAC 449.275, a residential facility must receive the permission requested pursuant to subsection 1 before the facility admits a resident who is otherwise prohibited from being admitted to the facility pursuant to paragraph (a) or (i) of subsection 4 of NAC 449.2702. 6. A residential facility may retain a resident who is otherwise prohibited			

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	from remaining as a resident of the facility pursuant to paragraph (a) or (i) of subsection 4 of NAC 449.2702 for 10 days after the facility submits to the Division the written request pursuant to subsection 1. Inspector Comments: Based on observation, record review and interview, the facility failed to submit an application for a waiver to retain a resident who had a nephrostomy tube (Resident # 5). Findings include: Resident #5 (R5) R5 was admitted on 11/22/24 with a diagnosis of hypertensive heart disease. On 05/13/26 in the morning, two tubes with drainage bags attached were observed hanging on the right side of R5's bed. One bag contained yellow fluid, and the other bag contained dark red, hazy fluid. At a later point in the survey, Employee #5 (E5) identified the first bag as the Foley catheter bag, and the latter bag as the nephrostomy bag. R5's file contained an approved medical exemption waiver dated 04/24/25 which listed conditions including Bedfast, Wounds, and Hospice, which expired after a year. A hospice certification narrative dated 03/26/26 documented R6 had retained a nephrostomy tube during a hospital stay dated 03/16/26, subsequent to hydronephrosis and kidney stone. On 05/13/26 in the afternoon, Employee #5 (E5) confirmed R5 had a nephrostomy tube, and that R6's current medical exemption waiver for the bedfast, wounds and hospice had expired. The facility submitted an application on 05/28/26 for a medical exemption and waiver for R6 for the conditions of Bedfast, Catheter, and Wounds. There was no mention in the waiver application of R6's			

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	nephrostomy tube. A Hospice Plan of Care dated 03/25/26 submitted with the application did not specifically name the nephrostomy tube, although the plan of care documented “hydronephrosis with renal and ureteral calculous obstruction” and “fitting and adjustment of urinary device.” In a phone interview on 05/29/26, a representative from R6’s hospice care company related from R6’s hospice nurse’s notes dated 05/25/26 that R5’s nephrostomy tube was in place and that 300 milliliters of dark fluid had been drained from the nephrostomy tube. Severity: 2 Scope: 1			
Y 0930 SS= E	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident.	Y 0930	1) This finding will be corrected by conducting a 2-step tb test for R6, R7, R8 and completing a yearly tb test for R3. 2) To avoid deficiency recurrence, a quarterly resident file/folder review willbe conducted to ensure documents are in compliance with the bureau's requirements. 3) The corrective action will be monitored by putting it into calendar which dates the reviews should be done. 4) The person assigned to complete this task will be the facility administratorand/or the facility staff. 5) The corrective action was completed on May 25, 2026 for R7, May 17, 2026 for R3, May 25, 2026 for R8 and a quantiferon blood draw was initiated for R6 on June 11, 2026. R6 quantiferon result was obtained on June 13, 2026 from her hospice provider.	06/11/2026

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	354	A. BUILDING _____ B. WING _____	05/13/2026

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	(b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a		6) Refer to the attached files for proof of completion.	

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	brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was			

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	354	A. BUILDING _____ B. WING _____	05/13/2026

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	discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 8 residents had completed Initial or Annual Tuberculin (TB) testing (Residents #3, #6, #7, and #8). Findings include: Resident #3 (R3) R3 was admitted on 04/07/16 with diagnoses including atherosclerosis of coronary artery, vascular dementia, and Type 2 Diabetes Mellitus. R3's file contained documentation of an annual TB test administered on 03/11/25 and read on 03/14/25. R3's file3 lacked documented evidence of an annual TB test conducted in 2026. Resident #6 (R6) R6 was admitted on 02/09/26 with a diagnosis of senile degradation of the brain.			

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	354	A. BUILDING _____ B. WING _____	05/13/2026

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	R6's file contained documentation of the first step of an Initial Two-Step TB Skin Test administered on 02/11/26 and read on 02/13/26. R6's file lacked documented evidence of the performance of the second step of the Two-Step TB Skin Test. Resident #7 (R7) R7 was admitted on 04/02/26 with diagnoses including dementia, chronic obstructive pulmonary disease (COPD), altered mental status, and purulent cellulitis-upper extremities. R7's file lacked documented evidence of an Initial TB test upon admission to the facility. Resident #8 (R8) R8 was admitted on 11/20/25 with a diagnosis of acute on chronic diastolic (congestive) heart failure. R8's file contained documentation of the first step of an Initial Two-Step TB Skin Test administered on 11/20/25 and read on 11/23/25. R8's file lacked documented evidence of the performance of the second step of the Two-Step TB Skin Test. On 05/13/26 in the afternoon, Employee #3 and Employee #5 acknowledged R3, R6, R7, and R8 had not completed the requirements of either Initial or Annual TB testing, as applicable to each. Severity: 2 Scope: 2			
Y 1825 SS= D	**NAC 449.0109 Designation and training of person responsible for infection control.** 3. The program to prevent and control infections within the facility for the dependent developed pursuant to	Y 1825	1) This finding will be corrected by ensuring E4's infection control certificates has been completed and included in her employee folder as soon as they have been issued. 2) To avoid this deficiency recurrence, a quarterly employee file/folder review will be conducted to ensure required training	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the secondary Infection Control designee had completed at least 15 hours of approved Infection Control training (Employee #4). Findings include: Employee #4 (E4)		certificates are updated to be in compliance with the bureau. 3) This corrective action will be monitored by putting into calendar which dates employee folder reviews/checking will be conducted. 4) The facility administrator and/or a facility staff will be assigned to complete this task. 5) The corrective action was completed on May 15, 2026. Surveyor has requested for a copy of the certificate of E4's infection control training via email and it was sent on that day. 6) Refer to the attached file for proof of completion.	

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	354	A. BUILDING _____ B. WING _____	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACHELE SENIOR GUEST HOME	3398 BANCROFT CIRCLE, LAS VEGAS, NEVADA ,89121

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	E4 was hired on 06/09/97 as the Administrator. E4 was named as the facility's secondary designee in charge of Infection Control. E4's file documented E4 completed at least 15 hours of Infection Control training provided by the Centers for Disease Control and Prevention (CDC) on 12/11/24. E4's file lacked documented evidence of Infection Control training in 2025 and 2026. On 05/13/26, Employe #3 and Employee #5 acknowledged E4's file lacked documentation of Infection Control training in 2025 and 2026. The facility was unable to provide documentation of Infection Control training completed by E4 in 2025 or 2026. Severity: 2 Scope: 1			
Y 1840 SS= E	**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	Y 1840	1) This finding will be corrected by ensuring E2 and E3 completes an unlicensed caregiver training for infection control. 2) To avoid this deficiency recurrence, a quarterly employee file/folder review will be conducted to ensure necessary trainings are updated to be in compliance with the bureau. 3) This corrective action will be monitored by putting into calendar which dates employee folders will be conducted 4) The facility administrator and/or a facility staff will be assigned to complete this task. 5) The corrective action was completed on June 11, 2026. 6) Refer to the attached file for proof of completion.	06/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	354	A. BUILDING _____ B. WING _____	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACHELE SENIOR GUEST HOME	3398 BANCROFT CIRCLE, LAS VEGAS, NEVADA ,89121

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	provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 3 unlicensed caregivers completed annual Infection Control training (Employees #2 and #3). Findings include: Employee #2 (E2) E2 was hired on 01/03/25 as a Caregiver. E2's file documented completion of three World Health Organization (WHO) Infection Control courses in 2024, and two undated WHO Infection Control courses. E2's file lacked documented evidence of Infection Control training provided by a nationally recognized organization in 2025 and 2026. Employee #3 (E3) E3 was hired as a Caregiver on 11/05/23. E3's file documented Infection Control Training provided by the CDC in January of 2025. E3's file lacked documented evidence of Infection Control training provided by a nationally recognized organization in 2026. On 05/13/26 in the afternoon, Employee #3 and Employee #5 acknowledged E2 and E3 lacked documentation of annual Infection Control training. Severity: 2 Scope: 2			