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
	4126	A. BUILDING _____ B. WING _____	07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT CARE GROUP HOME	639 K STREET, SPARKS, NEVADA ,89431

(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 a complaint investigation completed in your facility on 07/15/2026. The census at the time of the survey was five. The sample size was five. There was one complaint investigated. Complaint #13831 was substantiated. (See Tag Y0590) The investigation into the complaint included: Observation of grooming and physical appearance for residents, staff to resident interactions, staff response to telephone calls, and a tour of the facility. Interviews were conducted with residents, Caregivers, a Manager, and the Administrator. Clinical record review of five records, which included the resident of concern. Personnel record review of three records.			
Y 0590 SS= D	NAC 449.268 **Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response.** 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the	Y 0590	TAG Y 0590 The administrator of the facility failed to ensure about resident #4 was not prohibited from speaking to advocate for resident's right. The incident occurred when the social worker attempted to call the resident at the facility and the attending caregiver who answered the phone mistakenly believed the call was spam, as a result, the caregiver did not connect the call to the resident, unintentionally interfering with the resident's right to communication	08/09/2026

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	facility, another resident of the facility or any person who is visiting the facility; (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility; (c) The residents are treated with respect and dignity; (d) The facility is a safe and comfortable environment; (e) Residents are not prohibited from interacting socially; (f) Residents are allowed to make their own decisions whenever possible; (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner; (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new roommate; and (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document. 2. The administrator of a residential facility shall provide a procedure to respond immediately to grievance, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken.		The social worker had contacted the facility administrator directly after the incident and the administrator apologized, clarified the misunderstanding and ensure immediate access to the resident. The caregiver involved received immediate reprimand and immediate coaching on proper phone etiquette phone - handling procedures and resident rights regarding communication. To prevent recurrence, the facility has implemented and staff received refresher training on resident's right specifically the right to private communication, the right to speak with social workers, family, legal representatives and outside agencies without interference. Staff was educated about caller verification process. Staff must now ask the caller's name, role and purpose, to check facility's approved contact list when unsure and to call the administrator and transfer all calls to resident unless the resident declines. All caregivers had completed mandatory staff training on resident's rights, proper telephone etiquette and verification procedures and handling suspected spam calls without legitimate communication. The facility administrator will conduct weekly audits on phone logs and call - handling compliance. The administrator will perform random staff interviews to ensure understanding with updated protocol and to review any missed or declined calls to ensure proper handling. Any deviation will result to immediate retraining and corrective action. All staff reminded that all residents have the right to receive calls and verify before declining. The facility is committed to protecting resident's right and ensuring unrestricted communication with social worker and authorized individuals.	

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	3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2.			

Inspector Comments: Based on record review and interview, the Administrator failed to ensure 1 of 5 residents (Resident #4) was not prohibited from speaking to an advocate for resident rights.

Findings include:

Resident #4

Resident #4 was admitted to the facility on 12/31/2018 with diagnoses including chronic obstructive pulmonary disease, hypertension and coronary artery stenosis.

On 07/15/2026 at 9:02 AM, the Administrator explained staff were expected to answer calls on the facility telephone immediately or within two rings. The Administrator explained a Social Worker informed the Administrator the Social Worker had attempted to contact Resident #4 via the facility telephone. The Caregiver answered the telephone and refused to connect the Social Worker with the resident. The Administrator recounted a discussion with the Caregiver who acknowledged the encounter and explained the telephone rang constantly. The Administrator reprimanded the Caregiver and educated the employee to answer telephone calls.

On 07/15/2026 at 9:10 AM, the Manager explained staff were expected to greet telephone callers by saying “this is the caregiver. Can I help you?” The Manager verbalized approximately one month prior, the Caregiver answered a telephone call from the Social Worker, said “don’t call anymore,” and hung up the telephone. The Manager explained the Caregiver believed the telephone call was a scam call. The Manager and the Administrator educated the Caregiver to only refuse service after a telephone call was confirmed to be spam.

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	On 07/15/2026 at 9:46 AM, Resident #4 verbalized the resident was often visited by friends, social workers, and a fiduciary. The residents were able to use the facility telephone to make and receive telephone calls as desired. However, Resident #4 did not recall receiving telephone calls from any social worker. Complaint #13831 Severity: 2 Scope: 1			