STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9278	A. BUILDING _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTERNATIVE HOME CARE	**4504 LA ROCA CIRCLE, LAS VEGAS, NEVADA ,89121**

(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 and an annual survey initiated at your facility on 07/16/26 and finalized on 08/05/26. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category II residents. The census at the time of the survey was eight. Ten resident files and four employee files were reviewed. The sample size was ten. The facility received a grade of C. There was one complaint investigated. Substantiated: 1. Complaint#13036 was substantiated. (See TAG 620) The investigation of the complaint included: Observations of facility thermostat, facility use of bedrails, residents receiving care and a tour of the facility. Interviews were conducted with residents, Caregivers, the House Manager and the Administrator. Clinical Record Review of ten records. Document Review included electronic communication and facility policy and procedures.			
Y 0172 SS= F	NAC 449.209	Y 0172	A.The staff immediately called the maintenance guy while the survey was being conducted to adjust the water	08/06/2026

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	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.		temperature to 110 degrees Fahrenheit. The facilities landscaper had cleared the surrounding area and is now clear of debris and weeds. The filled-in backyard pool has been repaired by adding more rocks in it's surrounding. See attachment B. The Administrator and staff will conduct a monthly inspection of the facilities surrounding to ensure cleanliness and to have a safe environment for the residents. C. Accomplished August 6, 2026	

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	Inspector Comments: Based on observation and interview, the facility failed to ensure water temperatures were within the acceptable range of 100 degrees Fahrenheit (F) to 110 degrees Fahrenheit (F) for 2 of 2 resident bathrooms and failed to ensure the facility premises were well maintained. Findings include: On 08/05/26 in the morning, the water temperature in the resident bathroom near bedroom #2 registered 121.8 degrees Fahrenheit (F). The water temperature in the resident bathroom near bedroom #6 registered 115.9 degrees Fahrenheit (F). On 08/05/26 in the morning, weeds at the front of the facility were observed to be approximately 12 inches high on the right side of the driveway and 6 inches high along the front walkway. The backyard planters contained weeds approximately 6 inches high. On 08/05/26 in the morning, the filled-in backyard pool had a large depression in the center, creating a tripping hazard. On 08/05/26 in the morning, a caregiver acknowledged that the water temperatures were above the acceptable range of 100°F to 110°F and confirmed that the yard was not well maintained. Severity: 2 Scope: 3			
Y 0515 SS= F	NAC 449.259 **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	Y 0515	A. The Administrator and staff immediately had a Person-Centered-Service Plan for R4, R5, R6, R7, R8 and R9 respective charts. See attached documents. B. The Administrator and staff will ensure that a Person-Centered-Service Plan is done upon admission of a patient and annually thereafter. C. Accomplished August 06, 2026	08/06/2026

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	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 unscheduled activities that are suited to his or her interests and capacities;			

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	Inspector Comments: Based on interview and record review, the facility failed to ensure a Person-Centered Care plan was completed initially and/or annually for 6 of 10 sampled residents. (Resident #4, #5, #6, #7, #8 and #9) Findings include: Resident #4 (R4) R4 was admitted to the facility on 06/13/24, with a diagnosis of dementia. On 08/05/26 in the morning, Resident #4's file lacked an annual Person-Centered Service Plan for 2025 and 2026. The last documented Person-Centered Service Plan was dated 06/13/24. Resident #5 (R5) R5 was admitted to the facility on 01/04/23, with diagnoses including hypertension and seizure disorder. On 08/05/26 in the morning, Resident #5's file lacked an annual Person-Centered Service Plan for 2024, 2025 and 2026. The last documented Person-Centered Service Plan was dated 01/04/23. Resident #6 (R6) R6 was admitted to the facility on 01/10/25, with a diagnosis of chronic obstructive pulmonary disease. On 08/05/26 in the morning, Resident #6's file lacked an annual Person-Centered Service Plan for 2026. The last documented Person-Centered Service Plan was dated 01/10/25. Resident #7 (R7) R7 was admitted to the facility on 07/23/26, with a diagnosis of chronic kidney disease. On 08/05/26 in the morning, Resident #7's file lacked a completed initial Person-Centered Service Plan. R7’s file revealed a blank Person-Centered Service Plan dated			

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	07/23/26. Resident #8 (R8) R8 was admitted to the facility on 09/16/24, with diagnoses including cerebral infraction and hypertension. On 08/05/26 in the morning, Resident #8's file lacked an annual Person-Centered Service Plan for 2025 and 2026. The last documented Person-Centered Service plan was dated 09/16/24. Resident #9 (R9) R9 was admitted to the facility on 06/13/19, with a diagnosis of right hemiplegia. On 08/05/26 in the morning, Resident #9's file lacked an annual Person-Centered Service Plan for 2025 and 2026. The last documented Person-Centered Service Plan was dated 06/13/24. On 08/05/26 in the afternoon, the Caregiver acknowledged the finding and verbalized an initial Person-Centered Service Plan had not been completed for R7, and annual Person-Centered Service Plans had not been completed for R4, R5, R6, R8 and R9. Severity: 2 Scope: 3 This is a repeat deficiency from the 07/01/25 annual survey.			
Y 0620 SS= D	NAC 449.2702 and R089-24 4. Except as otherwise provided in this section and NAC 449.2736 and 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint;	Y 0620	A. The Administrator immediately asked the staff to lower down the bedside rail in question during the day of the inspection. Bedfast waiver has been applied for R2 and R4. See attached documents B. The Administrator reiterated to the staff to refrain from using the bedside rail hereafter. C. Accomplished August 20, 2021	08/20/2026

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	(c) Requires confinement in locked quarters; (d) Requires skilled nursing or other medical supervision on a 24-hour basis; (e) Requires gastrostomy care; (f) Requires vacuum-assisted wound closure therapy; (g) Requires dialysis, if the person is unable to leave the facility to obtain dialysis services; (h) Suffers from a serious staphylococcus infection or other serious infection; or (i) Suffers from any other serious medical condition or requires care not described in NAC 449.2712 to 449.2734, inclusive. 5. A residential facility that provides care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845, may admit or retain a resident who requires confinement in locked quarters. 6. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident suffering from a serious infection to remain a resident if the resident does not have symptoms that require a			

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	higher level of care than the residential facility is capable of providing. 7. A person may not reside in a residential facility if the person's physician or the Bureau determines that the person does not comply with the requirements for eligibility. 8. As used in this section, "restraint" means: (a) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (b) A manual method for restricting a resident's freedom of movement or the resident's normal access to his or her body; or (c) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or the resident's normal access to his or her body. **Reference - R089-24 Sec. 9.** "Bedfast" means: 1. Incapable of changing his or her position in bed without the assistance of another person; or 2. Immobile. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure bed rails were not used as a restraint (Resident #2) and failed to obtain a medical exemption to maintain one resident who was bedfast (Resident #4).			

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	Findings include: Resident #2 (R2) R2 was admitted on 03/19/26 with a diagnosis of dementia. R2 was asked a series of questions by the surveyor, however the resident appeared to be unable to answer the questions. On 07/16/26 in the morning, R2's bed was observed against the wall on one side and with half bed rails on the other. R2 could not lower the bedrails on R2's own. On 07/16/26 in the morning, a Caregiver indicated leaving R2's half rail in the up position while they are in bed, to prevent R2 from falling out of bed. On 07/16/26 in the morning, the Caregiver confirmed R2's bed was partially against the wall and had a half bed rail up on the opposite side. The Caregiver confirmed using a half bed rail for R2 to remain in bed and acknowledged R2 could not put the bed rail down on R2's own. Resident #4 (R4) R4 was admitted to the facility on 06/13/24 with diagnoses including dementia and hypertension. On 07/16/26 in the morning, R4 was unable to demonstrate the ability to turn from side to side in bed without assistance. On 07/16/26 in the morning, R4's file lacked documented evidence of an approved bedfast medical exemption from the Bureau. On 07/16/26 in the morning, a Caregiver confirmed R4 was unable to turn from side to side in bed without assistance and acknowledged R4 did not currently have an approved bedfast medical exemption on file. Severity: 2 Scope: 1 Complaint #13036			

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Y 0850 SS= D	NAC 449.274 and R043-22 **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.** 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide	Y 0850	A. The Administrator and staff immediately documented the incident report and filled the document on the patients chart. See attached document. B. The Administrator immediately reiterated the facilities policies and procedures on how to do a patients incident report to all staff. The Administrator and staff will take responsibility in making sure that any and all incident must be documented and filled in the patients chart and all involved parties are informed of the event. The Administrator will do a semi-annual training on the subject matter. C. Accomplished August 6, 2026	08/06/2026

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	that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on interview, document review and record review, the facility failed to ensure an incident report was completed for a resident who had a change of condition for 1 of 5 residents			

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	(Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/01/25 with a diagnosis of cerebral atherosclerosis. On 07/16/26 in the morning, a Caregiver reported R1 was sent out to the hospital on 03/13/26 due to R1's coughing. According to the Caregiver, R1 never returned to the facility. On 07/16/26 in the morning, R1's file lacked documented evidence of an incident report for R1's change of condition. On 07/16/26 in the morning, the House Manager acknowledged R1's file lacked documented evidence of an incident report for R1 being sent out to the hospital on 03/13/26. In an email dated 07/19/26 at 9:57 PM, the Administrator acknowledged R1 was discharged from the facility to the hospital on 03/13/26. According to the Administrator, the Administrator was unable to find any additional information regarding the change in R1's condition which led to R1 being sent out to the hospital on 03/13/26. Severity: 2 Scope: 1			
Y 0930 SS= F	**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.	Y 0930	A. The Administrator and staff made a immediate correction on the issue. The facility was able to obtain records from appropriate patients primary provider. The Administrator will ensure that all patients will receive annual PPD Test to be in compliance with the state requirements. See attached documentation B. The Administrator will also perform a semi-annual review of all patients chart to ensure that every patient in the facility has their vaccination up to date. C. Accomplised: August 6, 2026	08/06/2026

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	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. (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			

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	9278	A. BUILDING _____ B. WING _____	08/05/2026

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	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 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			

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	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 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 interview and document review, the facility 1) failed to ensure an annual tuberculosis (TB) test was completed for 2 residents (Resident #6 and #8) and 2) failed to ensure an initial and/or annual Activities of Daily Living (ADL) Assessment was completed for 6 of 10			

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	sampled residents (Resident #4, #5, #6, #7, #8, and #9). Findings include: Resident #4 (R4) R4 was admitted to the facility on 06/13/24, with a diagnosis of dementia. On 08/05/26 in the morning, Resident #4's file lacked an annual ADL Assessment for 2026. The last documented ADL assessment was dated 07/02/25. Resident #5 (R5) R5 was admitted to the facility on 01/04/23, with diagnoses including hypertension and seizure disorder. On 08/05/26 in the morning, Resident #5's file lacked an annual ADL Assessment for 2026. The last documented ADL assessment was dated 07/02/25. Resident #6 (R6) R6 was admitted to the facility on 01/10/25, with a diagnosis of chronic obstructive pulmonary disease. On 08/05/26 in the morning, review of R6's file revealed R6 completed an annual TB screening on 01/28/25 with a negative result. R6's file lacked documented evidence of a completed annual TB test, per the requirement. On 08/05/26 in the morning, R6's file lacked an annual ADL Assessment for 2026. The last documented ADL assessment was dated 01/10/25. Resident #7 (R7) R7 was admitted to the facility on 07/23/26, with a diagnosis of chronic kidney disease. On 08/05/26 in the morning, Resident #7's file lacked a completed initial ADL Assessment. R7's file revealed a blank ADL			

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	assessment dated 07/23/26. Resident #8 (R8) R8 was admitted to the facility on 09/16/24, with diagnoses including cerebral infraction and hypertension. On 08/05/26 in the morning, R8's file revealed R8 completed an annual TB screening on 01/10/25 with a negative result. R8's file lacked documented evidence of a completed annual TB test, per the requirement. On 08/05/26 in the morning, Resident #8's file lacked an annual ADL Assessment for 2025 and 2026. The last documented ADL assessment was dated 09/16/24. Resident #9 (R9) R9 was admitted to the facility on 06/13/19, with a diagnosis of right hemiplegia. On 08/05/26 in the morning, Resident #9's file lacked an annual ADL Assessment for 2026. The last documented ADL assessment was dated 07/02/25. On 08/05/26 in the afternoon, the Caregiver acknowledged R6 and R8's files lacked documented evidence of an annual TB test. The Caregiver confirmed an initial ADL assessment had not been completed for R7, and annual ADL assessments had not been completed for R4, R5, R6, R8 and R9. Severity: 2 Scope: 3 This is a repeat deficiency from the 07/01/25 annual survey.			
Y 1010 SS= D	NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for	Y 1010	A. The Administrator immediately gave the initial training to E4 on Mental Illness. B. The Administrator will ensure that all hired caregivers will have their initial training certificates on file and subsequent training will be taken on a timely manner. The Administrator will also perform a	08/06/2026

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	employees. 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. 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. 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. 3. As used in this section, “residential facility for persons with mental illnesses” means a residential facility that provides care and protective supervision for persons with mental illnesses, including, without limitation, schizophrenia, bipolar disorder, psychosis and other related disorders. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 sampled employees completed 8 hours of Mental Illness training within 60 days of hire (Employee #4). Findings include: Employee #4 (E4) E4 was hired on 01/30/26 as a Caregiver. E4 completed 4 hours of Mental Illness training on 04/30/26. On 08/05/26 in the afternoon, E4's file lacked documented evidence of an additional 4 hours of Mental Illness training per the requirement. On 08/05/26 in the afternoon, the House Manager acknowledged E4's 04/30/26		quarterly check on employee files to ensure that every caregiver will be in compliance with the required training, See attached document. Accomplished: August 6, 2026	

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	Mental Illness training did not meet the 8-hour requirement. 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	Y 1700	A. R1 was no longer a resident of the group home at the time of the survey, However, to address the cited deficiency and to ensure continued compliance, the group home has implemented the following corrective actions: Review of Discharged Resident Records prior to closing and archiving any discharged residents' file, the Administrator will review the record to ensure that all required documentation is complete and maintained in the residents file. Physician Assessment Determination: The group home will ensure that the required Physician Assessment Determination is maintained in each residents record as required, including after the resident has been discharged or is no longer residing at the group home. House Manager Responsibility: The House Manager will be responsible for verifying the completeness of each residents record prior to closing the file. Any missing required	08/11/2026

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	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 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		documentation will be identified and addressed before the records is archived. Ongoing Monitoring: The Administrator will conduct a quarterly review of discharged resident records to verify that required documentation, including the Physician Assessment Determination, is present and that records are maintained in accordance with applicable requirements. Prevention of Recurrence: This record-review process will be incorporated into the group homes discharged and record-closing procedures to prevent recurrence of the cited deficiency and maintain ongoing compliance. Person Responsible: The Administrator and Staff Monitoring Frequency: Quarterly and upon each resident discharge Compliance Goal: 100% of discharged resident records reviewed for required documentation prior to final closure and archiving.	

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	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 document review, record review and interview, the facility failed to ensure 1 of 5 sampled residents had a qualified provider of health care conduct an assessment of the condition and needs of a resident (Resident #1) to determine whether the resident met the criteria to reside in the facility. Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/01/25 with a diagnosis of cerebral atherosclerosis.			

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	R1's file contained a Physician's Placement Determination dated 12/10/24 from R1's previous facility. On 07/16/26 in the morning, R1's file lacked documented evidence of a Physician's Placement Determination completed upon R1's admission to the facility. On 07/16/26 in the morning, the House Manager acknowledged R1's Physician Placement was from 12/10/24. In an email dated 07/19/26 at 9:57 PM, the Administrator acknowledged R1's Physician's Placement Determination was completed on 12/10/24 at R1's previous facility. According to the Administrator, facility staff were unable to provide an explanation for the oversight. Severity: 2 Scope: 1			