

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9297	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER CECE GROUP HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5417 IRELAND ST., LAS VEGAS, NEVADA ,89149		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: DOROTHY DOMINGO Title: Residential Facility Administrator
REPRESENTATIVE'S SIGNATURE

Date: 07/11/2026

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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 State Licensure survey conducted at your facility on 06/16/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, mental illnesses and/or Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files and six employee files were reviewed. The facility received a grade of A. The following regulatory deficiencies were identified.			
Y 0878 SS= E	NAC 449.2742	Y 0878	TAG Y0878 - NAC 449.2742	07/11/2026

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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, the interpretation must be included in the		1. How the Specific Finding Will Be Corrected The Residential Facility Administrator and Facility Licensee (Owner) immediately reviewed all medication deficiencies identified during the survey. Resident #2: Hydralazine HCl was discontinued by the provider on 06/17/2026. The medication was discontinued on the Medication Administration Record (MAR),and immediately removed from the Resident's medication bin, and destroyed according to facility policy, documented on the Medication destruction record. The provider's discontinuation order was implemented immediately. Resident #4: The incorrect Vitamin D3 bottle was removed from the bin and destroyed according to facility policy. A new Vitamin D3 125 mcg bottle was immediately purchased, properly labeled with the resident's name and physician's name, and placed into the resident's medication supply. Resident #10: The Pantoprazole 40 mg physician's order was verified immediately upon the identification of the deficiency and the Medication Administration Record (MAR) was corrected to accurately reflect the current physician's order. Resident #10: The expired Refresh Eye Drops were immediately removed from bin, destroyed in accordance to facility's medication policy, and replaced with a new bottle. 2.Systemic Measures to Prevent Recurrence	

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	record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure 2 of 10 residents were administered medications as prescribed (Resident #4 and #10); 1 of 10 residents had a physician order to administer medications (Resident #10); and 1 of 10 residents did not have medications with range orders (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 05/24/25 with diagnoses including senile degeneration of brain, dementia, chronic kidney disease. On 06/16/26 at 1:45 PM, observed a medication package of Hydralazine HCL 25 milligrams (mg) take 1 tablet every 6 hours as needed for systolic blood pressure greater than 160 in R2's medication bin. Resident #4 (R4) R4 was admitted on 04/23/19 with diagnoses including atrial fibrillation, dementia, chronic kidney disease Stage 3 and hypertension. A physician order dated 05/05/26, documented Vitamin D3 125 micrograms (mcg) take 1 tablet daily. The June 2026 Medication Administration Record (MAR) reflected the physician order. The medication package read Vitamin D3 10 mcg take 1 tablet daily. On 06/16/26 at 2:15 PM, the Caregiver confirmed R4 was only administered one 10 mcg tablet daily in June, instead of the prescribed 125 mcg.		Residential Facility Administrator and Facility Licensee (Owner) re-educated all medication caregivers regarding verification of physician orders before medication administration, ensuring medication labels match current physician orders, immediate updating of the Medication Administration Record (MAR) whenever physician orders are changed, prompt removal and destruction of discontinued or expired medications, and verification that all newly purchased medications are correctly labeled before administration. 3. Monitoring to Ensure the Deficient Practice Does Not Recur The Residential Facility Administrator, Facility Licensee (Owner), and/or their designee will closely monitor medication management practices to ensure physician orders, Medication Administration Records (MARs), medication labels, and medication storage remain accurate and in compliance with facility policies and applicable regulations. Any deficiencies identified will be corrected immediately, documented as appropriate, and additional staff education will be provided as needed to maintain ongoing compliance. 4.Responsible Party Residential Facility Administrator and Facility Licensee (Owner) 5. Date Corrective Action Completed 06/17/2026 6. Supporting Documents • Photograph of the new Vitamin D3 125 mcg bottle	

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	Resident #10 (R10) R10 was admitted on 05/06/24 with diagnoses including chronic obstructive pulmonary disease, heart failure and back pain. A physician order dated 02/20/26, documented Pantoprazole DR take 1 40 mg tablet each morning for anti-ulcer. The June 2026 MAR documented Pantoprazole DR 40 mg take 1 tablet every AM. The MAR documented the medication was administered at 8:00 AM and at 5:00 PM every day in June 2026, not as prescribed. On 06/16/26 in the afternoon, two Caregivers confirmed the MAR documentation and that R10 was receiving 2 tablets of Pantoprazole DR 40 mg daily instead of 1 tablet as prescribed. On 06/16/26 in the afternoon, observed a bottle of Refresh Eye Drops, 2 drops in each eye twice a day for dryness in R10's medication bin. The medication label documented the eye drops expired on 06/22/25. There was no physician order for the eye drops and the MAR reflected no administration during the month of June 2026. Severity: 2 Scope: 2		• Photograph of the new Refresh Eye Drops • Corrected Medication Administration Record (MAR) for Resident #10, completed on 06/17/2026	
Y 0885 SS= E	NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or	Y 0885	TAG Y0885 – NAC 449.2742 1. How the Specific Finding Will Be Corrected The Residential Facility Administrator and Facility Licensee (Owner) immediately reviewed the deficiencies identified during the survey.	07/11/2026

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	a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure: 1) physician orders did not have an administration range for 1 of 10 residents (Resident #2); 2) discontinued medications were removed from 2 of 10 resident medication bins (Resident #3 and #4); and 3) medications for 2 of 10 residents had not expired (Resident #4 and #10). Findings include: Resident #3 (R3) R3 was admitted on 06/04/26 with diagnoses including heartfailure, chronic obstructive pulmonary disease and kidney failure. On 06/16/26 at 1:15 PM, observed a medication package for Hydroxyzine HCL 10 mg take 1 tablet every 8 hours as needed for anxiety. The medication was discontinued on 06/05/26, however the medication was still in R3's medication bin. On 06/16/26 at 1:15 PM, a Caregiver confirmed the discontinuedHydroxyzine was in R3's medication bin. Resident #4 (R4) R4 was admitted on 04/23/19 with diagnoses including atrial fibrillation, dementia, chronic kidney disease Stage 3 and hypertension.		The previously discontinued Hydroxyzine HCl 10mg medication was immediately removed from the medication bin and destroyed on 06/16/2026 in accordance with facility policy and documented on the Medication Destruction record. The expired Non-Aspirin 500 mg medication was immediately removed from the medication bin, destroyed according to facility policy and documented on the Medication Destruction record. Replaced with a new over-the-counter medication to continue as previously ordered. The expired Refresh Eye Drops were immediately removed from medication bin, destroyed according to facility policy, documented on the medication destruction record. Replaced with a new bottle to continue as previously ordered. 2. Systemic Measures to Prevent Recurrence The Residential Facility Administrator and Facility Licensee (Owner) re-educated all caregivers regarding prompt removal and destruction of discontinued and expired medications, verification of medication bins during medication passes, and maintaining compliance with facility medication management policies and applicable regulations. 3. Monitoring to Ensure the Deficient Practice Does Not Recur The Residential Facility Administrator, Facility Licensee(Owner), and/or their designee will closely monitor medication management practices to ensure discontinued and expired medications are removed promptly and destroyed according to facility policy. Any deficiencies identified will be corrected immediately, documented as appropriate, and additional staff education will be provided as needed. 4.Responsible Party Residential Facility Administrator and	

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	On 06/16//26 at 2:10 PM, observed a package of Non-Aspirin 50 mg take 1 tablet every 6 hours as needed for headache in R4's medication bin. The medication expired 08/2025 and had not been removed from R4's medication bin. Resident #10 (R10) R10 was admitted on 05/06/24 with diagnoses including chronic obstructive pulmonary disease, heart failure and back pain. On 06/16/26 in the afternoon, observed a bottle of Refresh Eye Drops, 2 drops in each eye twice a day for dryness in R10's medication bin. The medication label documented the eye drops expired on 06/22/25. On 06/16/26 in the afternoon, a Caregiver confirmed the observations of expired medications for R4 and R10, discontinued medications in a resident's medication bin for R3 and R4, and medication orders with a range for R2. Severity: 2 Scope: 2		Facility Licensee(Owner) 5. Date Corrective Action Completed 06/16/2026 6.Supporting Documents • Medication Destruction Record • Photograph of the new over-the-counter medication • Photograph of the new Refresh Eye Drops	
Y 0890 SS= E	NAC 449.2744 Administration of medication: Maintenance of logs and records; contents. 1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted	Y 0890	TAG Y0890 – NAC 449.2744 1. How the Specific Finding Will Be Corrected The Residential Facility Administrator and Facility Licensee (Owner) immediately reviewed all Medication Administration Record (MAR) documentation deficiencies identified during the survey.	07/11/2026

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	the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication. Inspector Comments: Based on observation, record review and		Resident#7: The MAR incorrectly documented Promethazine HCl as 125 mg instead of 12.5 mg. The error was corrected immediately on 06/16/2026, and the MAR was revised to accurately reflect the physician's order. Resident#9: The provider and hospice agency were immediately notified regarding the discrepancy involving Guaifenesin DM. The provider discontinued the medication on 06/17/2026. The MAR was updated immediately to reflect the discontinuation, and the discontinued medication was removed and destroyed according to facility policy, and documented on the Medication Destruction Record. Resident#10: The MAR documentation was immediately corrected to ensure caregivers initial the front of the MAR whenever medication is administered and complete the required documentation on the reverse side in accordance with physician orders and facility policy. 2. Systemic Measures to Prevent Recurrence The Residential Facility Administrator and Facility Licensee (Owner) re-educated all medication caregivers regarding accurate transcription of physician orders, verification of medication names, strengths, dosages and directions, proper MAR documentation, and immediate correction of discrepancies. 3. Monitoring to Ensure the Deficient Practice Does Not Recur The Residential Facility Administrator, Facility Licensee (Owner), and/or their designee will closely monitor MAR documentation practices. Any deficiencies identified will be corrected immediately, documented as appropriate, and additional staff education will be provided as needed. 4. Responsible Party Residential Facility administrator and Facility Licensee (Owner)	

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	interview, the facility failed to ensure the Medication Administration Record (MAR) was complete and accurate for 3 of 10 residents. (Resident #7, #9 and #10) Findings include: Resident #7 (R7) R7 was admitted on 12/01/25 with diagnoses including protein-calorie malnutrition. A physician order dated 12/15/25 for Promethazine HCL 12.5 milligrams (mg). The medication package reflected the physician order. On 06/16/26 at 1:55 PM, the MAR was documented as Promethazine HCL 125 mg. A Caregiver confirmed the error on the MAR. Resident #9 (R9) R9 was admitted on 08/16/24 with diagnoses including acute kidney failure, peripheral neuropathy and anxiety. A physician order dated 02/26/26, documented Guaifenesin/DM Syrup 200 mg/20 mg/20 milliliters (ml) take 10 ml every 4 hours as needed for cough. The medication package dispensed on 01/31/26 documented Guaifenesin/DM Syrup 200 mg/20 mg/20 ml take 20 ml every 4 hours as needed for cough. The medication was not listed on the MAR. On 06/16/26 at 2:05 PM, a Caregiver confirmed the different doses. Resident #10 (R10) R10 was admitted on 05/06/24 with diagnoses including chronic obstructive pulmonary disease, heart failure and back pain. A physician order dated 03/30/26, and the June 2026 MAR, documented Oxycodone 15 mg take 2 tablets every 4 hours as needed for breakthrough pain.		5.Date Corrective Action Completed 06/16/2026 6.Supporting Documents • Corrected MAR for Resident #7 • Provider Discontinuation Order dated 06/17/2026 for Resident #9 Corrected MAR for Resident #10	

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	The back of the MAR documented the Oxycodone was being administered 5-6 times daily during the month of June 2026. The June 2026 MAR did not document how many tablets were administered when given. The MAR was incomplete by not documenting the administration of Oxycodone on the front of the MAR. Severity: 2 Scope: 2			
Y 0920 SS= D	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-	Y 0920	TAG Y0920 – NAC 449.2748 1. How the Specific Finding Will Be Corrected The Residential Facility Administrator and Facility Licensee (Owner) immediately reviewed the medication storage deficiency identified during the survey. The medication lockbox located on top of the refrigerator was observed unlocked during the survey on 06/16/2026. The medication lockbox was immediately secured and locked upon notification by the surveyor. Staff were immediately re-educated that the medication lock box must remain locked whenever medications are not being accessed or administered. Corrective action was completed immediately to ensure compliance with facility policy and NAC 449.2748. 2. Systemic Measures to Prevent Recurrence The Residential Facility Administrator and Facility Licensee (Owner) re-educated all caregivers regarding proper medication storage procedures, including:	07/11/2026

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	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 until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secure. Findings include: On 06/16/26 at 10:05 AM, observed an unlocked black medication box on the top shelf of the refrigerator in the kitchen. At 10:05 AM, a Caregiver and the Administrator confirmed the observation. The Administrator reported the medication box contained medications for multiple residents and should have been locked. Severity: 2 Scope: 1		Ensuring all medications remain secured in a locked medication box or cabinet whenever not in use. Locking the medication storage area immediately after each medication pass. Allowing access only to authorized staff responsible for medication administration. Maintaining compliance with facility medication storage policies and applicable Nevada regulations. 3. Monitoring to Ensure the Deficient Practice Does Not Recur The Residential Facility Administrator, Facility Licensee(Owner), and/or their designee will closely monitor medication storage practices to ensure medications remain secured at all times and that staff consistently follow facility medication storage policies. Any deficiencies identified will be corrected immediately, documented as appropriate, and additional staff education will be provided as needed to maintain ongoing compliance. 4. Responsible Party Residential Facility Administrator and Facility Licensee (Owner) 5. date Corrective Action Completed 06/16/2026 6. Supporting Documents None. Corrective action was completed immediately by securing and locking the medication lockbox and re-educating staff regarding medication storage requirements.	