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
	11603	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME LLC	3970 MARYLAND AVE, 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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 12/18/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or mental illnesses, Category II residents. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 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. Inspector Comments: Based on observation and interview, the facility failed to ensure a tankless water heater did not have a water leak. Findings include: On 12/18/24 at 10:10 AM, observed a tankless water heater in a closet across from Room #6, with a leak. The leak was coming from a silver pipe leading from the water heater to the wall. There was visible corrosion on the pipe and a puddle of water on the wood flooring. The water stains on the pipe and wood flooring indicated it was not a new leak. On 12/18/24 at 10:10 AM, the Administrator and the Caregiver explained they were unaware of the leak. Severity: 2 Scope: 3	0178	1. In order to correct the citation, the leak was fixed. 2. In order for this deficiency not to re-occur, a monthly check of the unit was implemented. 3. The corrective action will be monitored by the caregivers by initialing the form and checking the unit once a month. 4. The caregivers and ADMINISTRATOR will monitor the plan of correction on monthly basis. 5. Corrective action was done on December 18, 2024. 6. Please see attached copy of the photo.	01/02/2025
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement	0878	1. In order to correct the citation, the physician was informed and requested for a written prescription for the over-the-counter medication. 2. In order for this citation not to reoccur, an order from the physician will be	01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11603	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME LLC	3970 MARYLAND AVE, 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
	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 record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on		requested for all over-the-counter medications. 3. The corrective action will be monitored by the Lead Caregiver, by requesting the doctors to write a written prescription for all over-the-counter medications. 4. The Lead Caregiver and ADMINISTRATOR will work together to ensure that the plan of correction is being implemented. 5. Corrective action was done December 18, 2024. 6. Please see attached copy of the written prescription. 1. In order to correct the citation, caregiver had I completely labeled the bottle as per instruction by the prescribing physician. 2. I don't sure that this deficiency will not reoccur, all medication bottles must be completely labeled, including the dosage directions residence name and the prescribing physician name. 3.Corrective action will be monitored by the lead caregiver and administrator by making sure that all bottles are completely labeled. 4. Lead caregiver and administrator will monitor that the plan of correction's implementation. 5.Corrective action was done on December 18, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11603	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME LLC	3970 MARYLAND AVE, 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
	observation, record review and interview, the facility failed to ensure there were physician orders for 1 of 8 residents (Resident #1); and a medication bottle lacked a prescription label for 1 of 8 residents (Resident #4). Findings include: Resident #1 (R1) R1 was admitted on 04/26/23 with diagnoses including congestive heart failure. On 12/18/24 at 10:00 AM, observed a bottle of Nervive in Room #6. R1 confirmed the observation and reported they used the medication for their back. R1 confirmed there was no physician order for the Nervive. R1's record lacked documented evidence of a physician order for Nervive. On 12/18/24 at 10:00 AM, the Caregiver acknowledged there was no physician order for the medication Nervive for R1. Resident #4 (R4) R4 was admitted on 06/14/24 with diagnoses including diabetes, hypertension, venous thrombosis and obesity. On 12/18/24 at 1:15 PM, a bottle of Xarelto 10 milligrams (mg), was in R1's medication bin. The bottle lacked a prescription label with the resident's name, the dosage directions and the ordering physician's name. R1's record documented a physician's order dated 10/18/24, take Xarelto 10 mg 1 tablet at bedtime. On 12/18/24 at 1:15 PM, the Caregiver confirmed there was no prescription label on the bottle of Xarelto to identify the resident, dosage amount and the physician. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11603	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME LLC	3970 MARYLAND AVE, 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
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (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; (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. Inspector Comments: Based on record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for a 1 of 8 residents. (Resident #7) Findings include: Resident #7 (R7) R7 was admitted on 10/04/24 with diagnoses including chronic pain, anxiety disorder and hyperlipidemia. On 12/18/24 at 1:45 PM, a physician order documented Alendronate Sodium 70 milligrams, take one tablet once weekly, Saturday PM. Alendronate Sodium treated or prevented osteoporosis. The December 2024 MAR documented the Alendronate Sodium as administered daily between 12/01/24 and 12/17/24 at 7:00 PM. On 12/18/24 at 1:45 PM, the Caregiver explained there was a documentation mistake on the December 2024 MAR and R7 was only receiving the medication on Saturdays at 7:00 PM. Severity: 2 Scope: 1	0895	1. In order to correct this citation, MAR was updated and corrected. 2. In order for this citation not to reoccur, MAR was corrected and made sure that the initials are to be done once a week, according to the instruction. 3. The corrective action will be monitored, by writing an X on the days that the medication is not given and initial only on the day it is given. 4. The Lead Caregiver and the ADMINISTRATOR will be responsible for ensuring that the plan of correction is implemented. 5. Corrective action was done on 18 December 2024. 6. Please see copy of the updated mar.	01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11603	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE CARE HOME LLC	3970 MARYLAND AVE, 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
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured. Findings include: On 12/18/24 at 10:00 AM, observed a bottle of Nervive in Room #6. Resident #1 confirmed the observation and reported they used the medication for their back. Resident #1 confirmed there was no physician order for the Nervive. On 12/18/24 at 10:00 AM, the Caregiver confirmed the observation of the unsecured Nervive and acknowledged there was no physician order for the medication. Severity: 2 Scope: 1	0920	1. In order to correct the citation, the physician was informed and requested for a written prescription for the over-the-counter medication. A box was provided in his room with a lock. 2. In order for this citation not to reoccur, an order from the physician will be requested for all over-the-counter medications and the locked box will be provided or they can store the medication. 3. The corrective action will be monitored by the Lead Caregiver, by requesting the doctors to write a written prescription for all over-the-counter medications. 4. The Lead Caregiver and ADMINISTRATOR will work together to ensure that the plan of correction is being implemented. 5. Corrective action was done December 18, 2024. 6. Please see attached copy of the photo of the locked container	01/02/2025