DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNIFIED CARE MANOR	**2915 EL CAMINO RD, LAS VEGAS, NEVADA ,89146**

(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 and Complaint Investigation survey, completed at your facility on 06/17/25, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was nine. Nine resident files and four employee files were reviewed. The facility received a grade of C. There were two complaints investigated. 1. Complaint #NV00073779 could not be substantiated. No regulatory deficiencies could be identified. 2. Complaint #NV00073640 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observation of grooming and physical appearance for residents, lack of odors, medical personnel onsite and tour of the facility. Interviews were conducted with the Administrator, Caregivers and residents. Clinical record review of nine residents, including the residents of concern. Document review of facilities Admission packet and Transportation Policy. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: GINALYN BALTAZAR-SUMBANG | Title: Administrator | Date: 07/29/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0104 SS= E	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview and record review, the facility failed to ensure a background check was completed every five years for 2 of 4 employees (Employee #2 and Employee #4). Findings include: Employee #2 (E2) E2 was hired in March of 2020 as the Administrator. Review of E2's employee record revealed E2 last completed a background check on 06/04/20. There was no documentation in the Nevada Automated Background Check System (NABS) of a current background check and no documentation of fingerprints in the employee record of E2. Employee #4 (E4) E4 was hired on 06/08/20 as the Owner. Review of E4's employee record revealed E4 last completed a background check on 06/04/20. There was no documentation in the Nevada Automated Background Check System (NABS) of a current background check and no documentation of fingerprints in the employee record of E4. On 06/17/25 at 11:10 AM, the facility was unable to provide documentation of a current background check or fingerprints for E2 and E4. On 06/18/25, at 11:45 AM, the Administrator confirmed E2 and E4 had not completed a background check or fingerprints in the five year required period. Severity: 2 Scope: 2	0104	1. The Administrator immediately updated background checks for Employee #2 and Employee #4 and have been completed and now on file. 2. The Administrator set up a log to track employee background check due dates and will review it regularly to stay compliant. 3. **Complete Date: 06/18/2025**	06/18/2025

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0357 SS= D	Bathrooms and Toilet Facilities - NAC 449.222 Bathrooms and toilet facilities; toilet articles. (NRS 449.0302) 7. Each resident must have his or her own toilet articles and must be provided with toilet paper, individual towels and washcloths. Paper towels may be used for hand towels. The towels and washcloths must be changed as often as is necessary to maintain cleanliness, but in no event less often than once each week. A soap dispenser may be used instead of individual bars of soap. Inspector Comments: Based on observation and interview, the facility failed to ensure hand drying towels/paper towels and hand soap were available in 1 of 3 bathrooms used by residents and guests. Findings include: On 06/17/25 at 12:15 PM, there were no hand drying items or soap available inside a bathroom used by residents and guests. On 06/17/25 at 12:17 PM, the Administrator and a Caregiver confirmed there were no paper towels or hand soap available in a bathroom used by residents and guests. Severity: 2 Scope: 1	0357	1. Facility Staff immediately stocked all the bathrooms with soap and paper towel supplies. 2. The Administrator instructed Facility Staff to check and restock bathroom supplies at each shift change to ensure all bathrooms remain fully stocked and maintained. 3. **Complete Date: 06/17/2025**	06/17/2025
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use	0690	1. The Administrator re-educated Facility Staff on proper oxygen tank storage and instructed them to immediately check and secure all oxygen canisters in Residents' rooms. 2. The Administrator assigned Facility Staff to check oxygen storage weekly to ensure compliance. 3. **Complete Date: 06/17/2025**	06/17/2025

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	of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen canisters were properly secured in the room of a resident. Findings include: On 06/17/25, in the morning, two oxygen canisters were found standing upright, outside of a holding rack, on the floor of a residents room. On 06/17/25, in the morning, the Administrator confirmed two oxygen canisters were not properly secured in the room of a resident. Severity: 2 Scope: 1			

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure all doors, which exited the facility, had an audible alarm. Findings include: On 06/17/25, in the morning, a sliding glass door, which led to the backyard, did not have a functional audible alarm when the door was opened. On 06/17/25, in the morning, a Caregiver confirmed a door, which led into the backyard, did not have an audible alarm because it was shut off. Severity: 2 Scope: 3	0991	1. Facility Staff immediately turned on the back patio door alarm. The Administrator re-educated Staff on door alarms in an Alzheimers facility, mainly to help keep wandering Residents safe. All exit doors were checked the same day to make sure alarms were working. 2. The Administrator assigned Staff to frequently check all exit door alarms are working properly and remain activated at all times. 3. **Complete Date: 06/17/2025**	06/17/2025

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0995 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure the main road was not able to be accessed by the residents from the back yard area and a gate leading to the main road was properly locked and secured. Findings include: On 06/17/25 in the morning, a gate on the right side of the home, separating the back yard from the front yard and main road, was found unlocked. On 06/17/25 in the morning, a Caregiver confirmed the gate on the right side of the home, which led to the street, was left unlocked. Severity: 2 Scope: 3	0995	1. The Administrator instructed Facility Staff to immediately lock and secure all backyard gates. All gates were inspected and secured. 2. Facility Staff will regularly check and ensure the gates remain properly locked and secured at all times. 3. **Complete Date: 06/17/2025**	06/17/2025
1540 SS= D	Cultural Competency Training - R004-24 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency	1540	1. The Administrator removed Employee #1 from the Staff Schedule until the required training is completed. 2. The Administrator will review training certificates during onboarding and annually to ensure compliance. 3. **Completed Date: 06/20/2025**	06/20/2025

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	training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267,			

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	chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on interview and record review, the facility failed to ensure Cultural Competency training was completed from an approved program, for 1 of 4 employees (Employee #1). Findings include: Employee #1 (E1) was hired on 12/02/24 as a Caregiver. Review of E1's employee record revealed Cultural Competency training was completed from an unapproved third party. On 06/17/25 in the morning, the facility was unable to provide documentation of Cultural Competency training from an approved program. Severity: 2 Scope: 1			

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1800 SS= D	30 Day PPE Required - NAC 449.01065 Requirements relating to personal protective equipment; exception for nursing pool. (NRS 439.200, 439.0302) 1. A medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall ensure that each person on the premises of the facility uses personal protective equipment in accordance with the publications adopted by reference in NAC 449.0106. The facility shall maintain: (a) Not less than a 30-day supply of personal protective equipment at all times; or (b) If the facility is unable to comply with the requirements of paragraph (a) due to a shortage in personal protective equipment, documentation of attempts by and the inability of the facility to obtain personal protective equipment. Inspector Comments: Based on observation and interview, the facility failed to maintain a 30 day supply of personal protective equipment (PPE) onsite and available for use. Findings include: On 06/17/25 in the morning, a check of the facilities PPE supplies, revealed there was a package of 25 facemask's available for staff, residents or visitors to utilize. On 06/17/25 in the morning, the Administrator was unable to locate a 30 day supply of facemask's within the facility. On 06/18/25 in the morning, the Administrator confirmed they could not find more than one pack of facemask's and did not have a 30 days supply worth of facemask's. Severity: 2 Scope: 1	1800	1. The Administrator immediately placed and order to replenish PPE supplies the same day to meet the required 30-day supply. Facility Staff were re-educated on the importance of maintaining required PPE supplies to ensure readiness for infection prevention and control. 2. The Administrator assigned Facility Staff to conduct weekly PPE inventory checks to ensure the required 30-day supply is maintained. 3. Complete Date: 06/17/2025	06/17/2025
1825 SS= D	Designation/Training persons for IC Program - 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 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	1825	1. EMPLOYEE #2 has completed the approved Infection Control Training Program on 04/20/2024. Based on the 3-year validity of the training, EMPLOYEE #2 remains current and compliant with the Infection Control Training requirement. 2. The Administrator will continue to monitor training certification expiration dates to ensure they are renewed on time.	06/17/2025

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	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 primary infection control manager completed 15 hours of infection control training annually (Employees #2). Findings include: Employee #2 (E2) was hired in March 2020 as the Administrator. E2 was identified as the primary infection control manager for the facility. E2's file documented E2 last completed 15 hours of infection control training on 04/20/24. On 06/17/25 in the afternoon, the Administrator confirmed E2 was the primary infection control manager, and had not completed a total of 15 hours of annual approved infection control training in the past 12 months. Severity: 2 Scope: 1		3. Complete Date: 06/17/2025	