STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9689	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD CARE HOME	5319 STAMPA AVE., LAS VEGAS, NEVADA ,89147

(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 completed at your facility on 02/05/25, 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, and/or persons with mental illnesses, and/or persons with intellectual disabilities, 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. 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 deficiencies were identified:	0000		
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation and interview, the Administrator failed to provide oversight and supervision to facility staff to ensure the facility was well-maintained and in compliance with the Nevada Administrative Code (NAC) 449. Findings included: The following tags were cited in this Statement of Deficiency (SOD) and lacked oversite by the Administrator. (Y0053) Failed to ensure employee records were complete and accurate. (Y0178) Failed to ensure the backyard was free of clutter and equipment. (Y0276) Failed to ensure food was not expired and proper defrosting techniques were used. (Y0300)	0050	**0050- Administrator's Responsibility - Oversight** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS) The Administrator and the group home Manager will complete all employee records, clean up backyards, check refrigerators and ensure medications were properly stored and secured. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); The Administrator and the group home Manager will both check all employee records, residents' records, backyard & front yard and all refrigerators at least once a week to avoid deficiencies. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS);	02/19/2025

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	Failed to ensure a resident was properly housed. (Y0690) Failed to ensure oxygen canisters were properly stored. (Y0920) Failed to ensure medications were properly stored and secured. Severity: 2 Scope: 3		A scheduled routine checks once a week in writing and signatures will be implemented to ensure the deficient practice will not recur. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); The Administrator, the group homeowner-provider and The Group Home Manager are responsible for ensuring the POC is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND On 2/6/2025, a staff meeting was convened, and corrective actions were implemented and completed. 6) You must attach all supporting documents into the email (MUST INCLUDE). Please see the following attached: employee records, backyard picture, refrigerator pictures, stored & secured medications on separate refrigerator	
0053 SS= C	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on interview and document review, the facility failed to ensure employee records were complete and accurate for 3 of 4 employees (Employee #1, Employee #2 and Employee #3). Findings include: Employee #1 (E1) E1 was hired as a caregiver. Review of E1's employee file revealed there was no documentation of a start date, a resume, an application or a back ground check clearance letter. Employee #2 (E2) E2 was hired in March 2023, as a caregiver. Review of E2's employee file revealed there was no documentation of a resume, an application	0053	**0053 Administrator's Responsibilities - Complete Records** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); The specific findings have been corrected the same day sent by text before 5PM and sent all documents required by email the following day on Feb 6, 2025, even though the deadline to submit was given until following Friday, Feb 7 thru email before noon. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); All employees' files have been completed and placed in each respective folder.	02/19/2025

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	or a back ground check clearance letter. Employee #3 (E3) E3 was hired as the Administrator. Review of E3's employee file revealed there was no documentation of a start date, a resume, an application, a back ground check clearance letter and training requirements which included elder abuse, cardiopulmonary resuscitation training, and annual caregiver training, had expired certificates. On 02/05/25, in the morning, a Manager confirmed the employee files for E1, E2 and E3 were incomplete and missing information related to start dates, background check clearance letters, resumes, applications and trainings. Severity: 1 Scope: 3		3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Every two weeks especially every new staff or employee that will be hired will complete all necessary documents most importantly fingerprinting. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); The Administrator and the Group Home Manager are responsible for ensuring the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND On 02/06/2025 all corrective actions are completed and submitted through email. 6) You must attach all supporting documents into the email (MUST INCLUDE). Attached are the following: Please see the following attached; 1.) Chronic Illness Training Cert - employee #4 (with the Infection Control Training of 2hrs) 2.) Chronic Illness Training Cert - employee #1 (with the Infection Control Training of 2hrs) 3.) Chronic Illness Training Cert - employee #2 (with the Infection Control Training of 2hrs) 4.) NABS -Clearance - Employee #3 5.) TB Test Questionnaire - Employee #3 6.) CPR - employee #3 -Note: this was sent to you via text yesterday 2-5-25 before 5pm 7.) Med Management -employee #3 8.) Elder Abuse -employee #3 9.) Infection Control Cert - employee #3 10.) Infection Control -Modules 1-13 - employee #3 11.) Infection Control Modules 14-15 - employee #3	

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			12.) Caregiving Continuing Ed - employee #3 13.) RN Caregiving Training - employee #3 14.) NABS Clearance - employee #2 15.) NABS Clearance - employee #1	
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 the backyard was free of debris and broken furniture. Findings include: On 02/05/25, in the morning, multiple items were found in the backyard, including bed frames, an unattached dryer, shopping carts, commodes, an unused refrigerator, dressers and multiple chairs used to block resident access to parts of the backyard. On 02/05/25, in the morning, a Caregiver and Manager confirmed there were multiples items stored in the backyard that needed to be removed or returned to medical supply companies. Severity: 2 Scope: 3	0178	**0178 Health and Sanitation** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS) While the survey was being conducted, the caregivers are clearing up the backyard with bedframes, shopping carts, commodes, chairs and others except for the dryer. It is working but we are waiting on the electrician to properly position and plug in the clothes dryer. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); The group home manager and employees have to be careful and quick in decision making as to where to place the items or return to supplier or throw if no place to properly store. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Backyard was cleared with hospital beds, refrigerator, dryer and extra chairs. Since those are considered clutter, no more extra furniture or appliances with be stored in the backyard. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); The Administrator, owner of the group home and the group home Manager are responsible in ensuring the plan of correction is implemented.	02/19/2025

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			5) The date the corrective action will be completed (MUST INCLUDE); AND As of 02/05/2025 while the survey was being conducted, and the following day, 02/06/2025, the group home manager and 2 hired people cleared the backyard. 6) You must attach all supporting documents into the email (MUST INCLUDE). Attached are the following: picture of cleared backyard	
0276 SS= F	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation and interview, the facility failed to ensure food was not expired, properly defrosted and was suitable for residents. Findings include: On 02/05/25 in the morning, the following were observed in the refrigerator: - A bottle of milk with an expiration date of 02/04/25. - A Italian meatloaf with an expiration date of 12/05/24. - A package of turkey breast lunch meat with an expiration date of 12/22/24. There were multiple containers of unidentified food with no hand written dates on the containers identifying what the food was, when the food was prepared and when the food should be discarded. On 02/05/25 at 9:15 AM, multiple food items including ground beef, frozen mac and cheese, frozen shrimp and eggs were observed sitting on the counter defrosting at room temperature. These items were observed at 10:00 AM still defrosting at room temperature. On	0276	**0276 Service of Food** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); The food that was defrosting was corrected and was placed in running water at the time of survey on 2/5/2025. Later in the same afternoon, a thorough clean-up was conducted in the refrigerator. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); The cook and caregivers were again instructed to check every day how to handle all food and storage before and after food preparation. They will be checked and reminded every week by the Administrator and the group home Manager. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); A separate food and storage do to lists is on the refrigerator door and now a part of an everyday "job to do" by the caregiver and the cook to ensure the deficient practice will not recur.. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS);	02/19/2025

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	00/05/25 in the morning, a Caregiver acknowledged there was expired food and multiple containers of food that did not have any documentation of what the food was or when it should be discarded in the refrigerator and confirmed they were improperly defrosting multiple food items at room temperature. Severity: 2 Scope: 3		The Administrator and the group home Manager are responsible for ensuring the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND In the afternoon of 2/5/2025, the corrective action was completed. Refrigerator was cleaned up with expired foods. And on 2/6/2025 the food and storage separate "to do lists" was posted by the refrigerator door in the kitchen 6) You must attach all supporting documents into the email (MUST INCLUDE). Attached are the following: Separate food and storage "to do lists" for the cook & caregiver.	
0300 SS= D	Bedrooms - Floor space - NAC 449.218 Bedrooms: Floor space; windows and doors; privacy; storage space; bedding; personal furnishings; lighting. (NRS 449.0302) 1. A bedroom in a residential facility that is shared by two or three residents must have at least 60 square feet of floor space for each resident who resides in the bedroom. A resident may not share a bedroom with more than two other residents. A bedroom that is occupied by only one resident must have at least 80 square feet of floor space. Inspector Comments: Based on observation and interview, the facility failed to ensure a bedroom, occupied by a single resident, had 60 square feet of floor space, ample hanging space and ample storage space for 1 of 9 residents (Resident #8). Findings include: Resident #8 (R8) was admitted on 06/02/20 with diagnosis including schizophrenia and chronic obstructive pulmonary disorder. On 02/05/25, in the morning, R8 was observed in a make-shift room, attached to the main house, which could only be reached by leaving the main house through the backyard. The room had a measurement of 60x85 inches, or 24% floor space. The room did not contain any hanging or storage space. On 02/05/25, in the morning, a Manager confirmed R8	0300	**0300 Bedrooms - Floor Space** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Resident #8 room has been enlarged and corrected. A contractor was hired to do the job. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); As of 2/19/25, an appointment with a contractor was scheduled and job to expand the room was completed. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); All resident bedroom's floor living space inside the residential group home were measured, inspected, passed and licensed. However, resident #8 is a special case that the owner/provider had to decide to keep. Resident #8 bedroom was enlarged to compliant size. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL	02/19/2025

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	occupied a space that did not have at least 60 square feet of floor space, ample hanging space or ample storage space. Severity: 2 Scope: 1		NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); The administrator, the group home manager and the owner/provider are responsible for ensuring the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND The contractor was hired as of 02/17/2025. Waiting on the plan, permits (need be), and materials. On 2/24/2025 the construction of additional living space begun and on 3/7/25, the project to enlarge the room was completed. 6) You must attach all supporting documents into the email (MUST INCLUDE). Attached are the following: Picture of additional living space.	

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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 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 (O2) canisters were properly stored and secured. Findings include: On 02/05/25, in the morning, three O2 canisters were found stored and unsecured, on the floor in a hallway closest. On 02/05/25, in the morning, a Caregiver confirmed there were multiple O2 canisters improperly stored in a hallway closet. Severity: 2 Scope: 1	0690	**0690 Use of Oxygen** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); The specific finding was corrected by calling the medical supplier and portable oxygen was replaced with the proper canisters. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); An agreement was created between the group home and the medical supplier to make sure the deficient practice will not recur. All portable oxygen that was empty will be picked up on a timely manner. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); All empty oxygen should be picked up within 24 hrs and be replaced immediately with all proper canisters. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); The Administrator, group home manager and caregivers that will sign and accept the newly delivered oxygen to ensure the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND On 02/07/2025, the group home manager called the medical supplier to pick up empty oxygen and replaced with newly usable portable oxygen. 6) You must attach all supporting documents into the email (MUST INCLUDE). See attached picture documents	02/19/2025

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0920 SS= F	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 resident medications located in a refrigerator, were properly secured. Findings include: On 02/05/25, in the morning, multiple suppositories were found stored in an unsecured refrigerator in the kitchen. On 02/05/25, in the morning, a Caregiver confirmed there were multiple suppositories stored in an unsecured refrigerator in the kitchen and should have been stored in a lockable medication refrigerator. Severity: 2 Scope: 3 This was a repeat deficiency from the 02/06/24 annual State Licensure survey.	0920	**0920 Medication Storage** 1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); The suppositories (the only medication in storage inside refrigerator) were moved to the standing small refrigerator for medications on 2/5/2025 during the survey. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); The group home will place in a locked box if placed inside the food refrigerator to ensure the deficient practice does not recur. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); All medications will be placed inside the dedicated medicine refrigerator to ensure the deficient practice will not recur. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); The Administrator, group homeowner, the group home manager especially the med-tech are the people responsible the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Same day of the survey on 2/05/2025, the corrective action was completed. 6) You must attach all supporting documents into the email (MUST INCLUDE). Please see attached picture.	02/05/2025