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
	10764	A. BUILDING _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT MOUNTAINS EDGE	9651 TRATTORIA STR, LAS VEGAS, NEVADA ,89178

(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 05/29/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 9 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 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		

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 REPRESENTATIVE'S SIGNATURE Name: ALLYN POVILAITIS Title: Administrator Date: 07/16/2025

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0106 SS= F	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 4 employees received in person cardiopulmonary resuscitation (CPR) training. (Employee #1, #2, #3 and #4) Findings include: Employee #1 (E1) E1 was hired on 03/17/25 as an Administrator. E1's file revealed CPR training was completed online on 05/01/25. E1's record lacked documented evidence of the CPR in person component. Employee #2 (E2) E2 was hired on 09/26/21 as a Caregiver. E2's file revealed CPR training was completed online on 04/06/25. E2's record lacked documented evidence of the CPR in person component. Employee #3 (E3) E3 was hired on 09/26/21 as the Administrator's Designee. E3's file revealed CPR training was completed online on 01/10/25. E3's record lacked documented evidence of the CPR in person component. Employee #4 (E4) E4 was hired on 03/26/25 as a Caregiver. E4's file revealed CPR training was completed online on 04/01/25. E4's record lacked documented evidence of the CPR in person component. On 05/29/25 in the morning, the Administrator Designee confirmed the online CPR training did not have the in person component for E1, E2, E3 and E4. The Administrator Designee acknowledged the in person component was required to be in compliance. Severity: 2 Scope: 3	0106	**1st Aid &CPR:** **1)** How you will correct the specific finding(s) stated in the Statement of Deficiencies? Employees 1,2, 3,& 4 have taken the proper course and certified for both CPR and 1st Aid as attached documentation verifies. **2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The facility will be sure to check the accreditation of the training class to be sure it is approved. **3)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The facility will be sure to check the accreditation of the training class to be sure it is approved. **4)** The title of the person (position) responsible for ensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator **5)** What date the corrective action will be completed? By June 8, 2025 **6)** Supporting Documents The documentation is attached.	06/06/2025

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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 interview, record review and document review the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 9 residents' medications (Resident #6). Findings include: Resident #6 (R6) R6 was admitted on 09/20/23, with diagnosis of dementia. A physician's order dated 03/14/24 documented Levothyroxine 200 micrograms (mcg), take 1 tablet daily in the morning on an empty stomach. The label on the medication documented Levothyroxine 200 mcg, take 1 tablet once daily in the morning on an empty stomach. The May 2025 MAR documented Levothyroxine 100 mcg, take 1 tablet by mouth everyday. On 05/29/25 in the morning, the Administrator Designee acknowledged the MAR was inaccurate and needed to be corrected to reflect R6's current physician's order. Severity: 2 Scope: 1	0895	**Administration of Medication Maintenance:** **1)** How you will correct the specific finding (s) statedin the Statement of Deficiencies? The Mar was corrected and is attached to this POC. The administrator will have a meeting with all caregivers to go over the regulation and make sure everyone understands the regulation and understands the **reason** for the regulation. **2)** What measures or systematic change (s) will be putinto place to ensure the deficient practice does not recur? The administrator will have a meeting with all caregivers to go over the regulation and make sure everyone understands theregulation and understands the reason for the regulation. In addition, the administrator will have a refreshercourse with the caregiver who made the mistake to make sure they follow theproper procedures. **3)** How the corrective action(s) will be monitored toensure the deficient practice will not recur? The administrator will review the MAR on a weeklybasis and oversee the caregiver's work. **4)** The title of the person (position) responsible forensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator **5)** What date the corrective action will be completed? The MAR was corrected by June 3, 2025 Correct MAR is attached	06/03/2025