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	11051	A. BUILDING _____ B. WING _____	11/19/2025

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THE WRIGHT GROUP HOME OF LOVELOCK	685 AMHERST AVE, LOVELOCK, NEVADA ,89419

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RFG 0001-Deficiencies	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	RFG 0001-Deficiencies		

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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 survey completed at your facility on 11/19/2025. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or mental illness and/or Alzheimer's/dementia, Category II residents. The census at the time of the survey was eight. Eight resident files and seven employee files were reviewed. The facility received a grade of D.			
Y 0074 SS= E	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually receive training to recognize and prevent theabuse of older persons before the	Y 0074	The owner hired the caregivers with a start date of 03/05/2025 and completed their training six days after. Since they could not access on the computer the elder abuse requirement took them a few more days to complete the training. Administrator will follow-up on the renewal date of all the trainings needed by the employees.	01/09/2026

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	license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse of older persons before the facility, agency or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care, facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter. 6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and			

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	(2) Facilities for intermediate care, facilities for skilled nursing, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section. 8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection. 9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on interview and personnel record review, the facility failed to ensure initial elder abuse			

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	prevention training was completed timely for 2 of 6 employees (Employees #4 and #5). Findings include: Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 03/05/2025. Employee #4's personnel record included an initial elder abuse prevention training completed 03/11/2025, six days after the employee's start date. Employee #5 Employee #5 was hired by the facility as a Caregiver with a start date of 03/05/2025. Employee #5's personnel record included an initial elder abuse prevention training completed 03/11/2025, six days after the employee's start date. On 11/19/2025 at 12:36 PM, the Owner verbalized the Owner believed staff could complete elder abuse prevention training 10 -15 days after commencing work at the facility. The Owner confirmed Employees #4 and #5 completed the training six days after starting at the facility and both employees worked with the residents prior to completing the elder abuse prevention training. Severity: 2 Scope: 2			
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or	Y 0250	The expired items on the pantry should have been removed by the caregivers. The first in first out methos should be practiced by the caregivers to ensure safety in using expired items. Canned goods should only be used if no fresh items are available. Owner should check expiration dated when buying canned goods. Administrator will follow-up on this matter.	01/09/2026

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	less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation and interview, the facility failed to ensure food items in the pantry were removed upon expiration. Findings include: On 11/19/2025 at 11:10 AM, the following expired food items were located in the kitchen pantry: -5-15-ounce (oz) cans of Mothers Maid Unsweetened Apple Sauce with an expiration date of 08/14/2025. -1-10.5 oz can of Sunny Select Turkey Gravy with an expiration date of 02/25/2024. -1-15 oz can of Ranch Style Beans with an expiration date of 06/23/2024. -4-14.5 oz cans of Delmonte Diced Tomatoes No Salt Added with an expiration date of 10/29/2025. -1-15 oz can of American Beauty Garbanzo Beans with an expiration date of 08/11/2025. -1-16 oz opened jar of Hampton Farms Creamy Peanut Butter with an expiration date of 08/13/2025. -1-11.5 oz bottle of WinCo Foods Tartar Sauce with an expiration date of 11/17/2025 -1-12 oz bottle of Kraft Tartar Sauce with an			

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	expiration date of 09/11/2025. -2-12 oz cans of Star-Kist Chunk Light Tuna in Water with an expiration date of 04/24/2025. -1-10 oz can of Raleys Chunk Chicken in Water with an expiration date of 04/19/2025. -1-18.5 oz can of Progresso Chipotle Corn Chowder with an expiration date of 06/20/2021. -2-5 oz cans of Raleys Chunk Light Tuna with an expiration date of 03/22/2025. -5-5 oz cans of Raleys Chunk Light Tuna with an expiration date of 10/14/2025. -2-5 oz cans of Raleys Chunk Albacore in Water with an expiration date of 05/18/2025. -2-5 oz cans of Mercantile & Fancy Chunk White Chicken with an expiration date of 05/11/2025. -4-5 oz cans of Mercantile & Fancy Chunk White Chicken with an expiration date of 07/30/2025. -9-5 oz cans of Mercantile & Fancy Chunk White Chicken with an expiration date of 09/12/2025. On 11/19/2025 at 12:01 PM, the Caregiver confirmed the above listed food items located in the pantry were expired and should have been removed. The Caregiver verbalized it was the responsibly of the caregivers to check the expiration dates of food items twice each month but was unsure how these expired food items remained in the panty and had not been removed. On 11/19/2025 at 1:29 PM, the Owner confirmed the food items listed above were expired and should have been removed from the pantry. Severity: 2 Scope: 3			
Y 0522 SS= F	NAC 449.259 (k) If the resident has Alzheimer's disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility,	Y 0522	Based on the finings of 7 of 8 residents with dementia diagnosis a person service centered plan should be completed on a timely manner with completed documentation. Administrator will se to it that the person centered plan should be done regularly with follow-up on caregivers to make sure the plan worked correctly.	01/09/2026

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	including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if: (I) It is determined through an assessment conducted pursuant to paragraph (c) of subsection 1 of NRS 449.1845 that the resident meets the criteria prescribed in paragraph (a) of subsection 2 of that section; and (II) The facility does not meet the requirements of NAC 449.2754 or 449.2756 or is otherwise unable to properly care for the resident. Inspector Comments: Based on record review, document review and interview, the facility failed to develop a complete person-centered service plan for a 7 of 8 sampled residents with a dementia diagnosis. Findings include: On 11/17/2025, during resident record review, service plans for 7 of 8 sampled residents lacked the following: -the manner in which the residents' behaviors would be managed. -the steps the facility would take to prevent the residents from wandering from the facility and how the facility would respond if the residents did so. -the criteria and provisions for the resident to be transferred or discharged from the facility if the facility did not meet the requirements to care for or were unable to property care for a resident with dementia. On 11/17/2025 at 1:12 PM, the Administrator confirmed the residents with a dementia diagnosis service plans were not complete and lacked specific documentation related to the residents' dementia diagnosis.			

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	Severity: 2 Scope: 3			
Y 0515 SS= F	NAC 449.259 **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must	Y 0515	Based on the findings of the survey that residents #'s 1 through 8 service plans were incomplete this was introduced to the facility lately. It used to be separate items but will have to accomplish this plan in a timely manner and promise this will not be repeated Administer will monitor regularly.	01/09/2026

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	inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review, document review and interview, the facility failed to develop complete person-centered service plans for 8 of 8 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: On 11/19/2025, during resident record review, service plans for 8 of 8 sampled residents lacked the following: -the type of protective supervision necessary for each resident. -the manner in which caregivers would be informed of the type of protective supervision for each resident. -the permission to leave and enter the facility, and physical and mental capabilities for each resident do so. -a written program of activities for the resident that includes scheduled and unscheduled activities suited to the resident's interests and capacities. -the steps to inform how each resident's valuables would be protected. On 11/19/2025 at 1:03 PM, the Administrator confirmed the residents' service plans were not complete and lacked documentation of all the required information to be included in the service plans. This was a repeat deficiency from the 01/23/2025 annual State Licensure survey.			

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	Severity: 2 Scope: 3			
Y 0876 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure an ultimate user agreement was completed for 2 of 8 sampled residents (Resident #2 and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/05/2025, with diagnoses including cognitive impairment and dementia. Resident #2's clinical record documented a signed ultimate user agreement; however,	Y 0876	Based on the findings of resident #2 and #3 with regards to the ultimate user agreement the caregiver missed that portion that they have to sign for resident #2 and #3. Will see to it that the administrator will follow up and continue to monitor the caregiver and owner and remind them that their signature is needed.	01/09/2026

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	lacked the facility representative's signature and date. Resident #3 Resident #3 was admitted to the facility on 05/18/2024, with diagnoses including dementia and hypertension. Resident #3's clinical record documented a signed ultimate user agreement; however, lacked the facility representative's signature and date. On 07/31/2025 at 1:24 PM, the Owner/Caregiver verbalized the facility needed to sign the ultimate user agreement. The Owner/Caregiver confirmed the ultimate user agreement was not signed for Resident #2 and #3. Scope: 2 Severity: 1			
Y 0905 SS= D	**NAC 449.2746** **Administration of medication: Restriction concerning medication taken as needed by resident; written records.** 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his need for the medication; (b) The determination is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the amount of medication that may be given, and the frequency with	Y 0905	Resident #3 November 2025 documented Venfelin HFA albuterol inhaler 90 mcg, inhale1-2 puffs by mouth every four hours, PRN for cough. Caregiver cannot decide on medication efficiency. Physicians order needed for clarification. Caregivers should be reviewed on the medication training classes. Will follow upon this concern.	01/09/2026

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	which the medication may be given. 2. A caregiver who administers medication toa resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) 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. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to ensure 1 a medication did not have a range order for 1 of 8 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 05/18/2024 with diagnoses including dementia and hypertension. Resident #3's November 2025 MAR documented Ventolin HFA 90 mcg inhaler. Inhale 1-2 puffs by mouth every four hours as needed for cough, wheeze, or shortness of breath.			

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	On 11/19/2025 at 1:14 PM, during a review of Resident #3's medications, a medication container documented Ventolin HFA Albuterol inhaler 90 mcg. Inhale 1-2 puffs by mouth every four hours as needed for cough, wheeze, or shortness of breath. On 11/19/2025 at 1:14 PM, a Caregiver explained if the Caregiver observed one puff of the Ventolin was not enough, the Caregiver would give the resident another puff. The Caregiver confirmed the facility was nonmedical and the Caregiver could not assess residents for medication efficacy. The Caregiver confirmed the physician's order for Ventolin required assessment by the facility and the facility did not reach out to the prescribing physician for clarification. Severity: 2 Scope: 1			
Y 0890 SS= D	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 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:	Y 0890	Resident #1's physicians order dated 9/25/2025 for lidocaine external patch 4%. Caregiver left the MAE blank due to resident refusal of said medication which should be administered 12 hours on and 12 hours off. Caregiver should document on the MAR refusal or "r" and note on the bottom or back of MAR the date and time of the refusal. Administrator will review on the caregivers medication training issue.	01/09/2026

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	(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, interview, and clinical record review, the facility failed to ensure a Medication Administration Record (MAR) was complete and accurate for 1 of 8 residents (Resident #1). Findings include: Resident #1			

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	Resident #1 was admitted to the facility on 03/04/2021 with diagnoses including hypertension and moderate chronic renal failure. A physician's order, dated 09/12/2025, documented Lidocaine External Patch 4 percent (%). Apply to the left hip topically in the morning for pain management and remove per schedule. A physician's order, dated 09/12/2025, documented Lidocaine External Patch 4%. Apply to mid back topically one time a day for mid back. Keep 12 hours on, 12 hours off. Resident #1's November 2025 Medication Administration Record (MAR) documented the following: -Lidocaine Pain Relief Patch 4%, apply one patch to left hip every morning for pain management and remove per pain schedule. The MAR lacked documentation related to the scheduled administration. -Lidocaine Pain Relief Patch 4%, apply to mid back topically one time a day for mid back. Keep 12 hours on and 12 hours off. The MAR lacked documentation related to the scheduled administration. Resident #1's clinical record lacked documentation the resident refused the Lidocaine Patch administrations and the Lidocaine was not administered. On 11/19/2025 at 1:25 PM, a Caregiver explained Resident #1 had physician orders to apply Lidocaine patches to the resident's hip and back once a day; however, the resident had refused the medication every day in November. The Caregiver left the MAR blank because the Lidocaine patches were not applied. The Caregiver verbalized the Caregiver did not document the resident refused the Lidocaine patch and the Lidocaine patch was not administered. Severity: 2 Scope: 1			
Y 0883 SS= D	NAC 449.2742 7. If a resident refuses, or otherwise	Y 0883	Resident #1 on order for lidocaine external patch 4%. apply to left hip and back once a	01/09/2026

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	misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on interview and clinical record review, the facility failed to ensure a physician was notified after a resident missed an ordered dose of medication for 1 of 8 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/04/2021 with diagnoses including hypertension and moderate chronic renal failure. A physician's order, dated 09/12/2025, documented Lidocaine External Patch 4 percent (%). Apply to the left hip topically in the morning for pain management and remove per schedule. A physician's order, dated 09/12/2025, documented Lidocaine External Patch 4%. Apply to mid back topically one time a day for mid back pain. Keep 12 hours on, 12 hours off. Resident #1's November 2025 Medication Administration Record (MAR) documented the following: -Lidocaine Pain Relief Patch 4%, apply one patch to left hip every morning for pain management and remove per pain schedule. The MAR lacked documentation related to the scheduled administration. -Lidocaine Pain Relief Patch 4%, apply to mid back topically one time a day for mid back. Keep 12 hours on and 12 hours off. The MAR lacked documentation related to the scheduled administration. Resident #1's clinical record lacked documentation the physician was informed of missed Lidocaine patch application.		day for pain management and removed per scheduled time. Should reflect on the MAR. Caregiver left the MAR blank due to refusal of the resident Caregiver should notify the physician within 12 hours immediately. Will review on medication training. Administrator will monitor caregivers administration of medication.	

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	On 11/19/2025 at 1:25 PM, a Caregiver explained Resident #1 had physician orders to apply Lidocaine patches to the resident's hip and back once a day; however, the resident had refused the medication every day in November. The Caregiver left the MAR blank because the Lidocaine patches were not applied. The Caregiver verbalized the Caregiver did not inform the physician after Resident #1 missed the scheduled Lidocaine Patch administration. Severity: 2 Scope: 1			
Y 0878 SS= E	NAC 449.2742 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:	Y 0878	Based on the findings of resident #5 November medication administration record. Facility needs to get a copy of the physicians order related to Ventalin Although the pharmacy cannot issue a medication without a physicians order caregiver realized that on record we did not have a copy of the order. Will get a copy from the pharmacy or the ordering physician. Will follow up n tis to ensure proper medical administration is done. Resident #2 required a change order label to accurately reflect the physicians order. Resident #$ an order for acetaminophen 650 m twice daily was changed to PRN and did not match the order. Change order label should reflect on the container.	01/09/2026

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	(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 observation, interview, and clinical record review, the facility failed to ensure 1) a physician's order was obtained by the facility prior to administering a medication for 1 of 8 residents (Resident #5), and 2) a change order label was affixed to a medication container for 3 of 8 residents (Resident #2, #1, and #4). Findings include: Order Resident #5 Resident #5 was admitted to the facility on 05/11/2022 with diagnoses including dementia and urinary tract infection. Resident #5's November 2025 medication administration record (MAR) documented Ventolin Hydrofluoroalkane (HFA) 90 micrograms (mcg) inhaler. Inhale one to two			

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	puffs by mouth every four hours as needed for cough, shortness of breath, or wheezing. The Ventolin was documented as administered on 11/03/2025 and 11/19/2025. Resident #5's clinical record lacked documented evidence of a physician's order related to Ventolin. On 11/19/2025 at 1:57 PM, during a review of Resident #5's medications, a medication container documented Ventolin HFA 90 mcg inhaler. Inhale one to two puffs by mouth every four hours as needed for cough, shortness of breath, or wheezing. On 11/19/2025 at 1:57 PM, a Caregiver verbalized all physician's orders needed to be obtained by the facility prior to administering a medication. The Caregiver verbalized being unable to locate the physician's order related to Resident #5's Ventolin. Label Resident #2 Resident #2 was admitted to the facility on 11/05/2025 with diagnoses including cognitive impairment and dementia. Resident #2's physician's orders, dated 11/05/2025, documented the following: -Quetiapine 25 milligrams (mg). Administer every evening with meal. -Quetiapine 25 mg. Administer one time daily as needed. Resident #2's November 2025 MAR documented the following: -Quetiapine 25 mg tablets. Take one tablet by mouth every evening. -Quetiapine 25 mg tablets. Take one tablet by mouth one time a day as needed for severe agitation. On 11/19/2025 at 1:21 PM, during a review of Resident #2's medications, a medication container documented Quetiapine 25 mg tablets. Take one tablet by mouth one time a day as needed for severe agitation. The			

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	resident's medications lacked Quetiapine 25 mg tablets related to a scheduled administration to be taken in the evening. On 11/19/2025 at 1:21 PM, a Caregiver explained a resident's MAR, medication label, and physician's order should match to ensure the correct dose was administered under the correct directions. The Caregiver verbalized the facility used Resident #2's container of as needed Quetiapine for both the as needed and scheduled doses. The Caregiver confirmed the medication required a change order label to accurately reflect the physician's orders. Resident #1 Resident #1 was admitted to the facility on 03/04/2021 with diagnoses including hypertension and moderate chronic renal failure. A physician's order, dated 09/12/2025, documented Lidocaine External Patch 4 percent (%). Apply to the left hip topically in the morning for pain management and remove per schedule. A physician's order, dated 09/12/2025, documented Lidocaine External Patch 4%. Apply to mid back topically one time a day for mid back. Keep 12 hours on, 12 hours off. Resident #1's November 2025 Medication Administration Record (MAR) documented the following: -Lidocaine Pain Relief Patch 4%, apply one patch to left hip every morning for pain management and remove per pain schedule. The MAR lacked documentation related to the scheduled administration. -Lidocaine Pain Relief Patch 4%, apply to mid back topically one time a day for mid back. Keep 12 hours on and 12 hours off. The MAR lacked documentation related to the scheduled administration. On 11/19/2025 at 1:25 PM, during a review of Resident #1's medications, a medication container documented Lidocaine Pain Relief Patch 4%. Apply one patch to the left			

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	hip every morning for pain management and remove per pain schedule. The resident's medications lacked Lidocaine Pain Relief Patch 4% related to a scheduled administration to be applied to the resident's mid back. On 11/19/2025 at 1:25 PM, a Caregiver verbalized the facility used Resident #2's container of Lidocaine Pain Relief Patches labeled for use on the left hip for both the left hip and mid back scheduled doses. The Caregiver confirmed the medication required a change order label to accurately reflect both physician's orders. Resident #4 Resident #4 was admitted to the facility on 08/20/2022 with diagnoses including dementia with behavioral disturbances and gastroesophageal reflux disease. A physician's order, dated 07/17/2025, documented to start Acetaminophen 650 mg. Take one tablet by mouth twice a day as needed for pain. On 11/19/2025 at 1:37 PM, during a review of Resident #4's medications, a medication container documented Acetaminophen 650 mg. Take one tablet by mouth twice daily. On 11/19/2025 at 1:37 PM, a Caregiver explained Resident #4's Acetaminophen order was recently changed from scheduled to as needed. The Caregiver confirmed the Acetaminophen label did not match the order and verbalized a change order label should have been affixed to the medication container. Severity: 2 Scope: 2			

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Y 1045 SS= C	**NAC 449.27704 (2)** **Placard: Issuance and display;** 2. The administrator shall, within 24 hours after receipt of the placard, display or cause the placard to be displayed conspicuously in a public area of the residential facility. Inspector Comments: Based on observation and interview, the Administrator failed to post the most current grade placard in the facility. Findings include: On 11/19/2025 at 10:54 AM, the grade placard posted on the dining room wall documented a survey date of 08/21/2024. The facility had received an annual survey completed on 01/23/2025. On 11/19/2025 at 1:07 PM, the Owner confirmed the posted grade placard was dated 08/21/2024 and the facility had an annual survey on 01/23/2025. The Owner verbalized having thought the most recent grade placard had been posted. Severity: 1 Scope: 3	Y 1045	The placard is important to the facility. Should be posted on a conspicuous place. Since the posted placard was dated 8/21/2024 and the annual survey was done on 1/23/2025. Owner was waiting for the current placard based on the survey of 1/23/2025. Administrator will remind the owner that the current grade placard be posted after the survey. Will follow up on this.	01/09/2026
Y 1810 SS= F	**NAC 449.0109** **Program and policy for control of infection; designation and training of person responsible for infection control. (NRS439.200, 449.0302)** 1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure	Y 1810	Will review on the infection control policies to prevent illnesses. Each employee had undergone the infection control training although the emergency preparedness plan was not on site at the time of the inspection. Will post the emergency plan on site. Administrator will follow up on this.	01/09/2026

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	that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and (c) Develop and carry out a comprehensive plan for emergency preparedness. 2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, 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. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on document review and interview, the Administrator failed to develop an infection control program, corresponding infection control policies to prevent illnesses, and an emergency preparedness plan to ensure the safety of the residents in the facility. Findings include: On 11/19/2025 at 12:36 PM, the facility lacked a complete infection control program and did not have infection control policies in place to ensure the safety needs of			

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	residents, staff and visitors. The facility also lacked an emergency preparedness plan addressing internal, external, local, and widespread emergencies. On 11/19/2025 at 12:38 PM, the Owner verbalized the facility had an infection control plan and policies as well as an emergency preparedness plan; however, both plans were not on site and available to be reviewed. Severity: 2 Scope: 3			
Y 1600 SS= C	**NAC 449.011943 and R004-24** **NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104)** 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender	Y 1600	Will update on the state guidelines based on SB364. Administrator will follow up.	01/09/2026

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	identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection1, include, without limitation: (a) The preferred name and pronoun ofthe patient or resident; (b) The gender identity or expressionof the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the			

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THE WRIGHT GROUP HOME OF LOVELOCK	685 AMHERST AVE, LOVELOCK, NEVADA ,89419

(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
	patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility failed to collect and include the residents' preferred name and pronoun in the residents' records. Findings include: On 11/19/2025, all the resident records lacked documented evidence of the residents preferred name and pronoun. On 11/19/2025 at 1:21 PM, the Owner/Caregiver confirmed the facility had not collected from any resident the resident's preferred name and pronoun in accordance with the resident's gender identity or expression and confirmed there was no place in the residents' records to document the information. Severity: 1 Scope: 3			