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 _____	**10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SRC SOUTHWEST	**7864 APACHE CLIFF, LAS VEGAS, NEVADA ,89113**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation initiated at your facility on 07/29/25 and completed at your facility on 10/01/25 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 Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Nine resident files and four employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated: 1. Complaint # NV00074455 was substantiated. (See Tag 556) The investigation of the complaint included: Observations of medication storage and the condition of the residents. Interviews were conducted with residents, caregiver staff, and the facility manager. Clinical Record Review of five records. Document review included the hospice visit log, the facility serious occurence report, and Medication Administration Records. The findings and conclusions of any investigation by the Division of Purchasing and Compliance 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: TIANA L SOSA Title: Manager Date: 01/02/2026

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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0170 SS= F	Health And Sanitation-Safe Water & Sewage - NAC 449.209 Health and sanitation. (NRS 449.0302) 1. A residential facility must: (a) Have a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage. Inspector Comments: Based on observation and interview, the facility failed to ensure facility water temperatures were maintained within a safe range. Findings include: On 07/29/25 at 10:07 AM, the water faucet temperature in the left hallway bathroom was very hot to the touch and the surveyor had to pull back their hand. The water temperature was measured with a thermometer and had a reading of 152.2 °F. At 10:22 AM, the water faucet temperature in the Master bathroom was 152 °F. Steam was observed coming up from the water flow. At 10:24 AM, the water faucet temperatures in the right hallway bathroom were 151 °F and 154.2 °F for the right-side and left-side sinks, respectively. On 07/29/25 at 10:25 AM, Employee #3 (E3) agreed the water temperatures were too high and verbalized they always burned themselves on the water from the left hallway bathroom. E3 verbalized that the water heater setting needed to be lowered by their maintenance personnel, as E3 was unable to change the setting. Severity: 2 Scope: 3	0170	1.The water heater was adjusted to a lower temperature 2.Water temps are checked on a weekly basis during weekly rounds to ensure this does not happen again 3.Checking water temperature is in our weekly rounds report to ensure this does not happen again 4.General manager will be responsible for checking 5.12/10/25 6.Current water temperature attached below	12/10/2025
0556 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093.	0556	1.Each facility has a narcotic log folder and we count medications beginning and end of every shift, we hold hospice nurses accountable as well by making sure they are checking their medications for their patients weekly 2.Counting medications and ensuring inventory is accurate 3.By reporting any medication errors or suspicions to the appropriate people 4.General manager will be sure this is implemented 5.12/10/25	12/10/2025

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	Inspector Comments: Based on document review and interview, the facility failed to report an allegation of suspected chemical restraint to Aging and Disability Services Division of 1 of 9 residents (Resident #8). Findings include: A physician order dated 04/10/24 documented R2 was prescribed Morphine Sulfate (Concentrate) by Mouth/Orally Solution 20 milligrams/milliliter (mg/ml) , 0.25 ml every hour as needed (PRN) for pain or shortness of breath. A facility-generated internal document dated 05/25 reviewed on 07/29/25 documented the occurrence of a 20-30 milliliter (ml) shortage of liquid Morphine by the facility. The facility's Nevada Division of Health Care Financing and Policy (DHCFP) Serious Occurrence Report dated June 2024 documented a medication error for R2. There was a low Morphine count with no documentation on R2's June Medication Administration Record to account for the low morphine count. The form documented a medical professional was not notified and the guardian/responsible person was not notified. Page 2 of the form, for the case worker's follow-up, was not filled out. On 07/29/25 in the morning, Employee #3 (E3) verbalized the facility suspected a former employee had administered R2's prescribed Morphine to Resident #8 (R8), a resident for whom it was not prescribed, for the purpose of calming R8 down. R8 was seen asleep between 3:00 and 4:00 PM during this time period. This was not R8's normal behavior, R8 would have been up at this time awake and exhibiting sundowning behaviors. R8's file lacked documented evidence they had a physician order for morphine. A physician order dated 06/12/24 documented Resident #9 (R9) was prescribed Morphine 20 ml-Oral, take 0.25 ml (5 mg) by mouth/under the tongue every four hours as needed for pain. On 10/01/25, E3 described how R9's morphine had not been documented in the June MAR as administered to R9. This was determined when a medication count was performed and there was a shortage of R9's		6.No documentation to upload	

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	Morphine. E3 reported that caregivers employed by the facility told E3 they thought the Lead Caregiver had administered R9's morphine to R8. On 07/29/25 in the morning, E3 explained the facility had not reported the allegation of chemical restraint to ADSD because they could not prove that medication diversion had occurred, despite their suspicions. Severity: 2 Scope: 1			
0557 SS= G	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation, record review and interview, the facility failed to ensure a bed rail was not used as a restraint causing an injury for 1 of 7 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 04/08/25 with diagnoses of altered mental status and anemia. On 07/29/25 in the morning, R1 was observed lying in bed that was positioned against a wall with the half rail up on the open room side. A pillow was located between R1's body and the half-rail. R1 had a bruise under their right eye, redness on their right eyelid, and what appeared to be a healing laceration on their forehead. On 07/29/25 in the morning, E2 explained R1 was unable to move their hands. On 07/29/25 in the morning, Employee #3 (E3) reported R1 had hit their face on the bed rail. E3 explained that sometimes R1 would get irritated, and because R1 could not move their hands, R1 would throw themselves around in the bed. E3 explained the half rail needed to be in place on the bed because R1 would roll out of the bed and fall to the floor. E3 verbalized the choice was between R1 hitting their face on the bed rail or R1 falling out of bed. R1	0557	1.The bed rail was removed 2.Moving forward we will not use bed rails even if the Doctor sends us a specific order 3.Checking residents daily and making sure they are able to use the rails for themselves for repositioning 4.Management will be checking this daily/weekly 5.12/10/25 6.We have uploaded a Drs order for the bed rail	12/10/2025

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	was sleeping at the time of discussion and was not able to be interviewed. R1's file contained an incident report which documented on 7/21/25 R1 became agitated and began throwing themselves into their bedrail. The staff came in and saw redness around R1's eyes and slight swelling. The facility notified R1's Hospice. Hospice came out, did an assessment and reported R1 was fine, and had some bruising around R1's face. Staff were now putting a pillow in front of the rail to avoid R1 from further injuries. On 07/29/25 in the morning, E3 acknowledged the raised half-rail on R1's bed posed a safety hazard, and that there were other measures such as fall mats and a new bed that could have been taken to ensure R1's safety in case of falls. Severity: 3 Scope:1			

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0740 SS= D	Residents Requiring Indwelling Catheter - NAC 449.272 Residents requiring use of indwelling catheter. (NRS 449.0302) 1. A person who requires the use of an indwelling catheter must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is physically and mentally capable of caring for all aspects of the condition, with or without the assistance of a caregiver; (b) Irrigation of the catheter is performed in accordance with the physician ' s orders by a medical professional who has been trained to provide that care; and (c) The catheter is inserted and removed only in accordance with the orders of a physician by a medical professional who has been trained to insert and remove a catheter. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure a medical exemption was submitted to the Bureau for 1 of 7 residents who had a Foley catheter (R1). Findings include: Resident #1 (R1) R1 was admitted on 04/08/25 with diagnoses including altered mental status and anemia. On 07/29/25 in the morning, R1 was observed lying in bed with a Foley catheter. R1 was not able to care for the Foley Catheter without assistance. Hospice orders dated 06/18/25 documented 10 milliliter (ml) balloon Foley catheter attached to a drain bag. On 07/29/25 in the morning, the facility Manager reported the caregivers drained the catheter bag and called Hospice if the bag was leaking or if they detected foul odors. Hospice would change the catheter bag once a week. The staff had training in providing care for the catheter. The facility lacked documented evidence of a medical waiver for R1's Foley catheter. On 07/29/25 in the afternoon, the Administrator acknowledged the facility had not applied for a medical exemption to retain R1 due to their Foley catheter. Severity: 2 Scope: 1	0740	1.The administrator applied for a waiver for said resident 2.Every resident will have a waiver for any of the following catheter/bedfast and wound care 3.We have a spreadsheet that is filled out for each resident which includes foley 4.Management will ensure this is implemented as well as the administrator 5.12/10/25 6.No documentation needed to upload	12/10/2025

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1540	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 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	1540		12/10/2025

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	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, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: **Entered in error.**			