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
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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 a Annual State Licensure survey completed at your facility on 04/17/25, 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 five. Five resident files and five employee files were reviewed. The facility received a grade of B. 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 investigations, 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		
0102 SS= F	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure a physical exam was completed for 2 of 5 employees (Employee #4 and Employee #5), and a two step tuberculosis (TB) screening was completed upon hire, for 4 of 5 employees (Employee #2, Employee #3, Employee #4 and Employee #5) Findings include: Employee #2 (E2) E2 was hired on 08/02/24 as a Caregiver. Review of E2's employee record revealed E2 had completed a TB one step screening on 06/10/24. There was no documentation E2 completed a second step TB screening. Employee #3 (E3) E3 was hired on 06/04/24/24 as a Caregiver. Review of E3's employee record revealed E2 had completed a one step TB screening on 06/06/24. There was no documentation E3	0102	**PHYISICAN EXAMS AND TBTESTS:** **1)** How you will correct the specific finding (s) stated in the Statement of Deficiencies? Employees 2,3,&5 have resigned as of April 15,2025 and they are moving back to Michigan. Their last Date of Services will be May 5, 2025 and therefore corrections will not be needed. All new staff hires will be required to have proof of their doctor exam and also their 2-step TB test along with any annual TB tests. Independent Contractor #4will have his Physician Exam and TB test done within a week. **2)** What measures or systematic change (s) will be putinto place to ensure the deficient practice does not recur? The facility will implement the caregiversDocuments and Requirements into a program called	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
	completed a second step TB screening. Employee #4 (E4) E4 was hired in 2024 as the Administrator. Review of E4's employee record revealed E4 had not completed a 2 step TB screening or a physical exam. Employee #5 (E5) E5 was hired on 08/08/24 as a Caregiver. Review of E5's employee record revealed E5 had completed a one step TB screening on 02/06/24. There was no documentation E5 completed a second step TB screening or a physical exam. On 04/17/25, in the morning, the Administrator confirmed there was no documentation E4 or E5 had completed a physical exam or E2, E3, E4 and E5 had two step TB screenings on file. Severity: 2 Scope: 3		DocuWhiz which will monitorand notify upcoming events which are required. **3)** How the corrective action(s) will be monitored toensure the deficient practice will not recur? The facility will implement the caregiversDocuments and Requirements into a program called DocuWhiz which will monitorand notify upcoming events which are required. **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? By May 1, 2025 **6)** Supporting Documents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
0106 SS= D	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 interview and document review, the facility failed to ensure cardiopulmonary resuscitation (CPR) training was completed for 1 of 5 employees (Employee #4). Findings include: Employee #4 (E4) was hired in 2024 as the Administrator. Review of E4's employee record revealed E4 had no documented CPR training. On 04/17/25, in the morning, the Administrator confirmed E4 had not completed CPR training. Severity: 2 Scope: 1	0106	**FIRST AID AND CPR:** **1)** How you will correct the specific finding (s) stated in the Statement of Deficiencies? Independent Contractor #4 will have his FirstAid/CPR Training completed. **2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The facility will implement the Administrators Documents and Requirements into a program called DocuWhiz which will monitor and notify upcoming events which are required. **3)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The facility will implement the caregivers Documents and Requirements into a program called DocuWhiz which will monitor and notify upcoming events which are required. **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 May 1, 2025 **6)** Supporting Documents	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
1036 SS= D	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. Inspector Comments: Based on interview and document review, the facility failed to ensure eight hours of Alzheimer's disease training was completed within 90 days of hire, for 1 of 5 employees (Employee #4). Findings include: Employee #4 (E4) was hired in 2024 as the Administrator. Review of E4's employee record revealed E4 had no documented Alzheimer's disease training on file. On 04/17/25, in the morning, the Administrator confirmed E4 had not completed Alzheimer's disease training. Severity: 2 Scope: 1	1036	ALZHEIMER'S/DEMENTIATRAINING: 1) How you will correct the specific finding (s) statedin the Statement of Deficiencies? Independent Contractor #4 will have his ALZHEIMER'S Training completed. 2) What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The facility will implement the Administrators Documents and Requirements into a program called DocuWhiz which will monitor and notify upcoming events which are required. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The facility will implement the caregivers Documents and Requirements into a program called DocuWhiz which will monitor and notify upcoming events which are required. 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 May 1, 2025 6) Supporting Documents	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
1600 SS= F	Preferred Name/Pronoun P& P - 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 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 subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of 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 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 interview and record review, the facility failed to ensure 5 of 5 residents files included documentation of preferred pronoun,	1600	**PREFERRED NAME/PRONOUNSP & P:** **1)** How you will correct the specific finding (s) stated in the Statement of Deficiencies? In the future, the facility has added this section into the Resident's Rental Agreement, so it will be filled out every time. **2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? Not only has the facility added this section into the Resident's Rental Agreement, it will be added to the Face Sheet of the DocuWhiz program. **3)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The DocuWhiz program will monitor and alert if the information is not filled out. **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 May 1, 2025 **6)** Supporting Documents	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
	gender expression and sexual orientation. Findings include: Review of 5 of 5 resident files revealed the facility did not document, residents preferred pronoun, gender expression and sexual orientation. On 04/17/25 in the morning, the Administrator confirmed there was no documentation of preferred pronoun, gender expression and sexual orientation for 5 of 5 residents, and this information was not on their admission documents. Severity: 2 Scope: 3			
1800 SS= F	30 Day PPE Required - NAC 449.01065 Requirements relating to personal protective equipment; exception for nursing pool. (NRS 439.200, 439.0302) 1. A medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall ensure that each person on the premises of the facility uses personal protective equipment in accordance with the publications adopted by reference in NAC 449.0106. The facility shall maintain: (a) Not less than a 30-day supply of personal protective equipment at all times; or (b) If the facility is unable to comply with the requirements of paragraph (a) due to a shortage in personal protective equipment, documentation of attempts by and the inability of the facility to obtain personal protective equipment. Inspector Comments: Based on observation and interview, the facility failed to ensure a 30 day supply of personal protective equipment was maintained and available onsite. Findings include: On 04/17/25, in the morning, the facility had no gowns, no N95 masks and had two face masks available onsite and available for use by staff and residents. On 04/17/25, in the morning, a Caregiver confirmed they did not have a 30 day supply of personal protective equipment onsite, which included face masks, gowns and N95 masks for residents and staff. Severity: 2 Scope: 3	1800	**30-DAY SUPPLY OF PPE:** **1)** How you will correct the specific finding (s) stated in the Statement of Deficiencies? Purchase 30-day supply of PPE. See Documentation **2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? Have installed an inventory system into QuickBooks and shall have a written monthly inventory that caregivers shall complete each month. **3)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Have installed an inventory system into QuickBooks and shall have a written monthly inventory that caregivers shall complete each month. **4)** The title of the person (position) responsible for ensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION)	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
			The Administrator 5) What date the corrective action will be completed? By May 1, 2005 6) Supporting Documents	