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 _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MONARCH AT HENDERSON	**1750 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012-4833**

(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 complaint investigation completed in your facility on 06/10/25, in accordance with in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 57. The sample size was five. The facility received a grade of A. There was one complaint investigated. Substantiated: 1. Complaint #NV00073812 was substantiated. (See TAG Y0503) The investigation of the complaint included: Observation of resident activities, staff providing care and assistance to residents, facility cleanliness, odors, infection control protocols and a tour of the facility. Interviews were conducted with residents, a Medication Technicians, a Housekeeper, the Activity Coordinator, the Wellness Director, and the Executive Director. Record review of five resident files and five staff files, which included the resident of concern. Document Review included the facility activity calendar, facility emails and facility policy and procedures. 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		
0503 SS= D	Written Policies - Compliance with - NAC 449.258 Written policies for facility; policy on visiting hours; residents ' mail; compliance with policies. (NRS 449.0302) 4. The employees of the facility shall comply with the policies developed pursuant to this section. Inspector Comments: Based on interview, record review, and document review, the facility failed to comply with their	0503	*Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JANE MICALI Title: Executive Director Date: 06/24/2025

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.

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 _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MONARCH AT HENDERSON	**1750 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012-4833**

(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
	established policy documented in the facility admission agreement regarding facility assistance with dental appointments for 1 of 5 sampled residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/01/23 with a diagnosis of dementia. R1's Admission Document dated 10/17/24 documented the facility would assist the resident in obtaining dental, optical care, treatment for hearing and hearing impairment, and social services. An email dated 09/02/24 at 12:14 PM from R1's family member to the facility asked if R1 had been scheduled for a dental appointment and cleaning. R1's family member reported dropping off the paperwork about a month ago for R1 to be enrolled in the in house visiting dental group. An email dated 09/03/24 at 8:24 AM from the Facility Concierge to the R1's family member documented they would follow up with the Wellness Office and have the answer by the end of the day. The Facility Concierge reported they were adding others to the email for visibility. An email dated 09/18/24 at 9:06 AM from the R1's family member to the Facility Concierge asked again if R1 had been scheduled for a dentist visit. An email dated 09/18/24 at 10:25 AM from the facility Wellness Director to the Concierge documented they had not scheduled R1's appointment yet since the bus would be taken. An email dated 06/10/25 at 4:54 PM from the facility Executive Director acknowledged facility email documented the bus was not available for R1's dental appointment. According to the Executive Director, the facility does assist with all outside appointments. On 06/10/25 in the morning, there was no documented evidence of a dental visit in R1's record. On 06/12/25 at 7:58 AM, the Wellness Coordinator verbalized the facility used to have an in-house dental program and acknowledged there was no documented evidence onsite that R1 had received dental services. Severity: 2 Scope: 1 Complaint		**A. With Respect to the Specific Residents/Area Cited:** **Resident #1 no longer resides in the community.** The Executive Director reviewed the Residency Agreement requirements that directed, the community will assist the residents in obtaining dental, optical care, treatment for hearing and hearing impairment, and social services. The Executive Director review the Residency Agreement requirement with the Wellness Director and Sales Director. **Completion Date:06/25/2025** **B. With Respect to How the Community will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:** The Executive Director and Wellness Director added Dentist contact information to resident contacts. The Wellness Director requested resident responsible party to communicate the resident's dentist appointment support needs. The Wellness Director reviewed and updated resident Service Plans to indicate the interventions for dental care and appointments managed by the community or by the resident’s responsible party. **Completion Date: Ongoing** **C. With Respect to What Systemic**	

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 _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MONARCH AT HENDERSON	**1750 WEST HORIZON RIDGE PARKWAY, HENDERSON, NEVADA ,89012-4833**

(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
	#NV00073812		**Measures have been put in place to Address the Stated Concern:** The Executive Director and Wellness Director conducted in-service training for the community department directors and care team to review the requirements for assisting residents with obtaining dental care, making appointments, communication with the resident responsible parties, Executive Director and the Wellness Director. **Completion Date: 06/23/25** **D. With Respect to How the Plan of Corrective Measures will be Monitored:** The Wellness Director will review dental care service appointments scheduled and follow-up action steps with the Executive Director during weekly 1:1 meeting. The Executive Director will maintain a file of the meetings. **Completion Date: 7/10/2025** .	