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 _____	**06/26/2025**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 06/26/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 56. The sample size was five. The facility received a grade of A. There was one complaint and one Facility Reported Incidnet (FRI) investigated. Substantiated: 1. Complaint #NV00074572 was substantiated. (See Tag's Y0050 and Y0966) 2. FRI #11764 was substantiated. (See Tag's Y0050 and Y0966) The investigation of the complaint and FRI included: Observation of staff providing care to residents, the couryard, and staffing ratios. Interviews were conducted with Caregivers, Medication Technicians, Wellness Coordinator, Wellness Director, and the Administator. Record review of residents, which included the resident of concern. Document Review included facility policy and procedures, incident report, and staff schedule. 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		
0050 SS= J	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS.	0050	Resident1 no longer resides in the community. **Y0050** 1.The door Locks to the courtyards both in Sage Brush and Blue bird were changed to a numeric punch code. Courtyard access is controlled by team members.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JANE MICALI Title: Executive Director Date: 09/03/2025

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.

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	Inspector Comments: Based on observation, interview, record review, and document review the Administrator of the facility failed to provide sufficient staffing and oversight to prevent a resident from accessing a secured courtyard area, resulting in a resident ' s death. (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 04/08/21 with diagnoses including dementia, psychotic disturbance, anxiety, and mood disturbance. A facility Incident Report dated 06/16/25, documented at approximately 6:45 PM, a Medication Technician (Med Tech) entered R1's room to administer medication and discovered R1 was not in their room. After checking nearby areas and confirming with a Care Partner that R1 had not been seen recently, the staff initiated a Code Green. Code Green meant staff were to search for a missing resident. R1 was found unresponsive in the Sage Brush courtyard and emergency services were contacted at 7:11 PM. R1 was pronounced deceased at the scene. On 06/26/25 at 9:45 AM, the doors leading to all courtyards were locked from the inside of the facility and accessible to open from the outside to gain entry back into the facility. There were no residents or staff in the dining area or the courtyards. The Sage Brush courtyard where R1 was found deceased was accessible from the dining room on the North end of the building. The door to the courtyard was locked from the inside and required a key to open. The courtyard door chimed when staff unlocked and opened the door, and the chime was not loud enough to be heard in nearby hallways. The camera installed to view the courtyard was not operating at the time of inspection. There were no cameras inside the dining room. To view the courtyard from the dining area staff would have to walk to the back of the room and view the area from the window. There was a book located in the Sage Brush dining room for hourly checks to ensure no residents		Re-entry from courtyard does not require a key or punch code access. Completion Date 07/15/25. See Attached 2.a. Courtyard door Alarms are scheduled for replacement. The replacement door alarms are high pitched audible alarms that require team members to reset the alarms with a key. See attached b. Plant Ops. Director will conduct audible alarm functionality checks weekly. c. Plant Ops Director will communicate to Executive Director about any functionality issues and action steps that were taken, Completion date 8/21/25. 3.a. Community has installed a new camera system that provides clear view in both Sage Brush and Blue Bird Dining rooms. b. Cameras were installed in all 3 courtyards that allow full courtyard visibility.	

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	were in the courtyards which was implemented after R1 was found deceased in the courtyard. The book had been documented in by staff from 8:00 AM through 8:00 PM and was implemented after the incident occurred on 06/16/25. R1's Level of Wellness Review (Care plan/Activities of Daily Living (ADL) assessment) dated 01/30/25 documented R1 required active assistance with toileting and personal hygiene. Included was the Safety Assessment which documented R1 was at risk for wandering out of the community and frequency of checks was once per shift. The Level of Wellness Review did not document two-hour checks as part of the care plan. The Level of Wellness Review lacked documented evidence of any interventions or procedures in place to ensure R1's safety, aside from staff awareness R1 was at risk for wandering. R1's Elopement Risk Assessment dated 06/06/25 documented a score of 32, indicating R1 was a high risk for Elopement. R1 was noted to wander aimlessly and had a history of prior elopement attempts. There was no documented evidence R1 had eloped from the community; however, R1 was assessed as exit seeking which made R1 an elopement risk. The facility's Elopement Risk and Intervention policy dated 12/01/14, required monitoring measures for residents identified as elopement risks, including supervision and care planning. On 06/26/25 in the morning, camera footage reviewed with the Administrator showed the last image of R1was on 06/16/25 at 4:12 PM walking in the hallway near the Sage Brush dining area. No further footage was available due to poor camera quality and lack of surveillance coverage in the courtyard. The camera footage was not clear enough to indicate if staff were in the hallway or not when R1 was noticed on the camera. On 06/26/25 at 9:45 AM, the Administrator reported all the courtyard doors were always kept locked from the		c. Cameras were installed to view all 4 hallways. (100 hall 200 hall 300 hall and 400 hallways). The Executive Director has reviewed camera access. Completion Date 6/28/25. See attached 4.a. Community Team members conduct hourly courtyard checks between the hours of 8 A.M.- 8. P.M. See training sheet attached. b. The Executive Director and Wellness Director will review during daily stand-up. c. Community established courtyard access protocol that prohibits resident access when temperatures are 90 degrees and above. See community posting attached. Completion date 06/20/25 5a. Wellness Director has reviewed and updated resident service plans to indicate their ADL assistance needs to include residents who may require more frequent checks. b. Wellness Director has reviewed and updated current resident safety assessments to indicate resident safety plan interventions for resident safety. c. Wellness Director has reviewed Elopement risk policy and has updated the current residents' assessments to identify interventions for elopement and for residents at risk for exit seeking. See attached	

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	inside and required a key to open. The Administrator was uncertain how R1 exited, as the door could not be opened from the inside without a key. No staff had reported allowing R1 into the courtyard. Since the incident with R1 occurred, the facility had implemented post-incident safety measures, including hourly courtyard checks and escort requirements for residents entering outdoor areas. On 06/26/25 at 10:20 AM, Employee #2 (E2), a Care Partner, reported on 06/16/25 E2 had worked a double shift due to staffing shortages for the second day in a row. Care Partners were also responsible for setting up the dining room for meals so once the Care Partners received the end of shift report from the previous shift, they would report to the dining room to set up for meals. E2 was normally assigned to the 200/300 hall. E2 further reported that on 06/16/25 from 6:00 AM to 2:00 PM and 2:00 PM to 10:00 PM E2 was assigned the 400 hall where R1 resided. E2 received an end of shift report however there was not enough time to fully understand the needs of unfamiliar residents. E2 had not provided care to R1 in a couple of months and was not familiar with R1. The Care Partner from the night shift provided a verbal end-of-shift report and explained R1 had been unusually lethargic and sleeping most of the day on both 06/15/25 and 06/16/25, which was a notable change from R1's typically active and disruptive behavior. E2 attempted to dress R1 in the morning, but R1 was combative and refused to go to the dining room, so R1 received a room tray for breakfast, which was delivered by a Med Tech. E2 indicated all residents required a two-hour check, however due to being short-staffed, Care Partners could not consistently perform two-hour checks and prioritized residents at higher risk; R1 was not considered a high risk because R1 was not considered a fall risk. R1 had some disruptive behaviors which included banging on the door to the lobby and the		d. Wellness Director has reviewed missing resident policy and reviewed Resident plan procedure See attached Completion date 08/30/25. 6a. The community implemented a team member daily assignment sheet to ensure team member accountability and to know the whereabouts and safety measures for our residents, b. Executive Director and Wellness Director will follow up with training and counseling to prevent deficient practices as they can lead up to a team member's termination. c. Documentation of a team member's deficient practice will be placed in team members' personnel file. Completion date ongoing. 7 a. The Executive Director removed care partner's responsibilities for Dining room set up and clean up for meals/ b. The Food and Beverage department is responsible for set- up and clean- up for all meals. Completion date 6/30/25. 8.a. The care team will document and communicate follow-up needs in the 24-hr. report. b. Care team will review the 24-hr. report at the beginning and ending of each shift. c. Wellness Director will participate in the shift huddles while on duty and ensure the supervisor on duty participates in Team	

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	door leading to the kitchen. On 06/16/25, E2 last provided care to R1 at 11:00 AM and reported seeing R1 walking near the Sage Brush dining room around 4:00 PM. On 06/26/25 at 11:12 AM, Employee #3 (E3), a Med Tech, communicated E3 delivered R1's lunch tray shortly before 12:00 PM. R1 had been agitated in the morning and had returned to their room around 10:30 AM. E2 and E3 had assisted R1with grooming. E3 did not see R1 after lunch and reported all residents required a two-hour check; however, the facility was short-staffed on 06/16/25, affecting monitoring ability. On 06/26/25 at 11:45 AM, Employee #9 (E9), the Wellness Coordinator, reported Care Partners were expected to complete rounds every two hours for all residents, including R1. Most of the time, R1 remained continent and used the restroom independently but had experienced a decline recently, which included occasionally using a brief during the day and night. Care Partners were therefore expected to check on R1 every two hours to ensure the brief was not wet. During the day, staffing included two Med Techs and up to six Care Partners. Med Techs were assigned five to seven residents to help reduce the Care Partners' workload. E9 was not aware of a six-to-one staffing requirement for Alzheimer's endorsed facilities. E9 reported R1 would sometimes bang on doors but had never gone outside and had consistently declined offers to go outdoors. On 06/26/25 at 12:15 PM, Employee #4 (E4), the Wellness Director, confirmed the facility operated with six Care Partners and two Med Techs based on census. E4 was unaware of the one-to-six caregiver-to-resident staffing requirement for Alzheimer's endorsed facilities and acknowledged the facility was not following it at the time of the incident with R1. E4 communicated R1 had behaviors of banging on doors that lead to the outside; however, had never gotten out of the community. A review of the staff schedule revealed for the month of June		member shift huddles to ensure shift to shift communication of the residents and community needs. d. Care partners will communicate any changes in resident health status to the Wellness Director, Executive Director or the shift supervisor. e. The Executive Director will provide coaching and training to E2 to communicate all residents' health status requirements and ensure shift huddles are taking place. All care team members are required to participate in reviewing resident service plans. This will ensure that we are providing the residents' care daily. Completed 6/20/25 See attached 9a. E2, E3, E6, E7, and E8 have received coaching and training regarding resident ADL's and only one care partner should be grooming one resident at a time and to notify Executive Director and Wellness Director if additional assistance is needed. b. The Executive Director provided coaching and training for E2, E3, E6, E7, and E8 on the requirement for providing ADL assistance and reporting health status changes for the residents and interventions. Completed 6/20/25.	

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	2025, the facility was continuously short staffed by one to three Care Partners based on an average census of 53 to 55 residents. The Medication Technicians (Med Tech)/Care Partner schedules were as follows: the AM shift ran from 6:00 AM to 2:00 PM, and the afternoon shift ran from 2:00 PM to 10:00 PM. On 06/16/25, the day of the incident, the facility census was 53 residents, requiring a minimum of nine Med Techs/Care Partners per shift to meet the one to six staff-to-resident ratio. The AM shift had two Med Techs and four Care Partners and was short staffed by three Care Partners. One additional Care Partner was present but was in training and was shadowing another staff member and was not counted toward active staffing. The afternoon shift had two Med Techs and four Care Partners, also falling short by three Care Partners. On 06/26/25 at 1:00 PM, Employee #7 (E7), a Care Partner, confirmed R1 had never previously exited the facility and was not known to attempt elopement. E7 reported staffing shortages made it difficult to complete the required two-hour safety checks on 06/16/25. On 06/26/25 at 1:20 PM, Employee #8 (E8), a Med Tech, reported to last seeing R1 in the morning, R1 was agitated but not exit-seeking. E8 explained the courtyard door alarms did not transmit to radios and only emitted a chime which was hard to hear if you were not near the Sage Brush dining area/courtyard. On 06/26/25 at 3:50 PM, Employee #6 (E6), a Med Tech, reported that all residents required two-hour checks. R1 was not assigned to E6; however, E6 normally saw R1 walking around frequently. E6's shift had started at 3:00 PM on 06/16/25 and E6 had not seen R1 the whole shift. All Care Partners and Med Tech's assisted during the dining service. Dinner dining service begins at 5:00 PM. R1 usually ate later in the evening and slept through dinner. E6 indicated that if a resident did not show up to dinner it was protocol to bring a meal tray to that			

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	resident. E6 did not check on R1 to see if R1 was awake and wanted a meal tray. At 6:45 PM during medication pass, E6 was unable to locate R1 and R1 was not in R1's room. After a building-wide search, R1 was found lying in the grass in the courtyard, unresponsive. Emergency services were contacted immediately. Review of the facility's Missing Resident Procedure policy dated 07/01/19 required staff to search courtyards and outdoor areas as part of initial search efforts. However, no evidence showed the courtyard was checked until the final stages of the Code Green initiated on 06/16/25. Severity: 4 Scope: 1 Complaint #NV00074572 FRI #11764			
0966 SS= G	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on observation, record review and interview, the facility failed to maintain the required resident to staff ratio and adequate supervision during waking hours for an Alzheimer's endorsed facility resulting in lack of supervision for a resident who was found deceased in a courtyard (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 04/08/21 with diagnoses including dementia, psychotic disturbance, anxiety, and mood disturbance. On 06/16/25, R1 was found lying on the ground in the Sage Brush courtyard unresponsive and was pronounced deceased. See Tag 0050. On 06/16/25, the day of the incident, the census at the facility was 53 residents. The facility needed nine Med Techs/Care	0966	1.a The Executive Director implemented 1-6 staffing ratio as required by the state regulations b.The Executive Director reviewed staffing ratio requirements with community team and the communication requirements for call outs to ensure we have adequate coverage according to our one staff to 6 resident ratio. c. The wellness Director will participate in the shift huddles while on duty and ensure the supervisor on duty participates in Team to ensure we are staffed appropriately with 1to 6 member shift huddles to ensure shift to shift communication of the residents and community needs and to ensure all residents care needs will be met with appropriate staffing according to one to 6 staff to resident ratio. d. Care partners will communicate any changes in resident health status to the Wellness Director, Executive Director or the shift supervisor or any staffing issues.	

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	Partners to meet the required one staff to six resident ratio. A review of staff schedules revealed, the AM shift consisted of two Med Techs and four Care Partners, and the facility was short staffed by three Care Partners. An additional Care Partner was on duty on the AM shift who was in training shadowing another Care Partner who was not counted towards the total Care Partners. The afternoon shift consisted of two Med Techs and four Care Partners, and the facility was short three Care Partners. A review of staff schedules for the month of June 2025 revealed, the facility was short staffed by one to three Care Partners daily or 30 days of the month. The Medication Technicians (Med Tech)/Care Partner schedules were as follows: The AM schedule was from 6:00 AM - 2:00 PM and afternoon schedule was from 2:00 PM - 10:00 PM. Employee schedules for the month of June 2025 were reviewed and showed all shifts in June were understaffed with the following dates sampled: On 06/01/25, the census at the facility was 55 residents. Ten Med Techs/Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and five Care Partners, and the facility was short three Care Partners. On 06/03/25, the census at the facility was 53 residents. Nine Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and five Care Partners, and the facility was short two Care Partners. On 06/06/24, the census at the facility was 52 residents. Nine Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and five Care Partners, and the facility was short two Care Partners. On 06/09/25, the census at the facility was 53 residents. Nine Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and five Care Partners, and the facility was short two Care Partners. On 06/12/25, the census at the facility was		e. The Executive Director will provide coaching and training to E2 to communicate all residents' health status requirements and ensure shift huddles are taking place. All care team members are required to participate in reviewing resident service plans. This will ensure that we are providing the residents' care daily with staffing according to our one to 6 staffing ratio which is regulated by the state of Nevada. See Updated Staffing ratio grid attached. Completed 08/21/25.	

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	53 residents. Nine Care Partners were needed to meet the staffing ratio. The AM shift consisted of two Med Techs and five Care Partners, and the facility was short two Care Partners. The afternoon shift consisted of two Med Techs and six Care Partners, and the facility was short one Care Partner. On 06/15/25, the census at the facility was 54 residents. Nine Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and four Care Partners, and the facility was short three Care Partners. On 06/16/25, the day of the incident, the census at the facility was 53 residents. The facility needed nine Med Techs/Care Partners to meet the ratio of one staff member for six residents to meet the required one staff to six resident ratio. A review of staff schedules revealed, the AM shift consisted of two Med Techs and four Care Partners, and the facility was short staffed by three Care Partners. An additional Care Partner was on duty on the AM shift who was in training shadowing another Care Partner who was not counted towards the total Care Partners. The afternoon shift consisted of two Med Techs and four Care Partners, and the facility was short three Care Partners. On 06/17/25, the census at the facility was 53 residents. Nine Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and five Care Partners and the facility was short two Care Partners. On 06/20/25, the census at the facility was 54 residents. Nine Care Partners were needed to meet the staffing ratio. The AM shift consisted of two Med Techs and four Care Partners and the facility was short three Care Partners. The afternoon shift consisted of two Med Techs and five Care Partners and the facility was short two Care Partners. On 06/23/25 the census at the facility was 53 residents. Nine Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and five Care			

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	Partners and the facility was short two Care Partners. On 06/26/25 at 9:30 AM, during an on-site inspection the census at the facility was 56 residents. Ten Med Techs/Care Partners were needed to meet the staffing ratio. The AM and afternoon shift consisted of two Med Techs and six Care Partners, and the facility was short two Care Partners to meet the required one staff to six residents ratio. On 06/26/25 at 10:20 AM, Employee #2 (E2), a Care Partner, reported working a double shift due to staff shortages for the second day in a row on 06/16/25. E2 indicated all residents required two-hour checks; however, due to being short-staffed, Care Partners could not consistently perform two-hour checks and prioritized residents at higher risk such as a fall risk and R1 was not considered a fall risk On 06/26/25 at 11:12 AM, Employee #3 (E3), a Med Tech, reported all residents required two-hour checks; however, the facility was short-staffed on 06/16/25, which affected the ability to monitor residents properly. On 06/26/25 at 11:45 AM, Employee #9 (E9), the Wellness Coordinator, explained Care Partners were expected to complete rounds every two hours for all residents, including R1. Most of the time, R1 remained continent and used the restroom independently but had experienced a decline, occasionally using a brief during the day and night. Care Partners were therefore expected to check on R1 every two hours to ensure the brief was not wet. Staff included two Med Techs and up to six Care Partners, with Med Techs assigned five to seven residents to assist with Care Partners' workload. E9 was not aware of a six-to-one staffing requirement. On 06/26/25 at 12:15 PM, Employee #4 (E4), the Wellness Director, confirmed on a daily basis the facility operated with six Care Partners and two Med Techs based on census and acknowledged the facility was not following the one-to-six Caregiver-to-resident staffing requirement at the time. On 06/26/25 at			

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 _____	**06/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	1:00 PM, Employee #7 (E7), a Care Partner, confirmed staffing shortages made it difficult to complete the required two-hour safety checks on 06/16/25. On 06/26/25 at 3:50 PM, Employee #6 (E6), a Med Tech, reported that all residents required two-hour checks but E6 did not check on R1 that evening until 6:45 PM for medication pass. E6 was unable to locate R1 prompting a building-wide search that found R1 unresponsive in the courtyard. Severity: 3 Scope: 1 Complaint #NV00074572 FRI #11764			