STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11493	A. BUILDING _____ B. WING _____	01/22/2026

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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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 a complaint and Facility Reported Incident (FRI) investigation completed in your facility on 01/22/26. The census at the time of the survey was 61. The sample size was four. The facility received a grade of C. There was one complaint and one Facility Reported Incident (FRI) investigated. Substantiated: 1. Complaint# 12699 was substantiated. (See TAGs Y515, Y850 and Y992) 2. FRI # 12663 was substantiated. (See TAGs Y515, Y850 and Y992) The investigation of the complaint included: Observations of residents receiving care and a tour of the facility. Interviews were conducted with residents, the resident of concern, a Caregiver, a Medication Technician, the Wellness Coordinator, the Wellness Director and the Administrator. Clinical Record Review of five records. Document Review included police reports, employee schedules and facility policy and procedures.			
Y 0515 SS= D	NAC 449.259	Y 0515		02/17/2026

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	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 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		Corrective Action Taken for Resident (R1) 1. The Wellness team (Administrator, Wellness Director, Wellness Coordinator immediately conducted a full reassessment of Resident 1. Wellness Director received a corrective action for not adhering to company policy. 2. A new service plan for change of condition has been updated to reflect: a. Fracture care needs/use sling. b. Mobility assistance and supervision. c. Pain Management protocols. d. Safety precautions two - person assist. See Attached Completion Date: 2/17/26 Corrective Action to Prevent Reoccurrence The Wellness Director conducted a 100% audit of all resident service plans for: recent hospitalizations, incident reports (including but not limited to falls and injuries), and any changes in mobility or cognition. A new service plan will be completed. **Any abuse allegation are immediately reviewed and investigated.** Clear communication protocol to notify Wellness Director or the Administrator so the issue can be addressed immediately,	

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	or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to update a person-centered service plan after a resident experienced a change in condition. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/20/25, with a diagnosis of dementia. A Nurse Follow Up Visit dated 12/04/25 from R1's Advanced Practice Registered Nurse documented an x-ray completed on 12/03/25 demonstrated R1 had an acute, comminuted, nondisplaced fracture of the left humerus at the surgical neck. Given R1's advanced age, R1 was ordered a sling for immobilization as tolerated, and pain medication was initiated for comfort. R1's file revealed R1's last Person-Centered Service Plan was completed on 11/19/25 and lacked documented evidence how the facility would provide care to R1 after R1's left humerus was fractured. On 01/22/26 in the morning, the Wellness Director acknowledged R1 experienced a change in condition on 11/30/25 when R1's left humerus was fractured. The Wellness Director confirmed the service plan dated 11/19/25 lacked documented evidence of how the facility would care for R1's given R1's recent change in condition. Facility Resident Abuse Policy dated 07/01/19 documented an interdisciplinary team must assess, develop, update and implement interventions into the wellness plan for each resident based on the needs and interests of the residents. Severity: 2 Scope: 1		and the care plan be updated. The same protocol will apply for any allegation of abuse that occurs during weekends or overnight hours. Reinforce "Call 911 First "for any abuse that is witnessed, a resident experiences significant injury, a fall results in severe pain or suspected fracture. Completion Date: 03/31/26 Systematic Changes • The facility implemented a Change in Condition Care Plan Protocol requiring: Service plan updates within 24 hours of any significant change within Monday – Friday. • A Care Plan Update Checklist was added to the electronic health record. • Incident reports now automatically trigger: LPN review, Care plan review, interdisciplinary team meeting when necessary. • Daily huddles with caregiving staff with a supervisor present. • Administrator and Wellness Director shall provide daily oversight as often as needed for resident care. • Administrator, Wellness Director, Wellness Coordinator shall conduct Random Quality Assurance Care Audits with staff: that includes drop-in observation and demonstration for	

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	Complaint# 12699 and FRI# 12663		resident care. • Wellness Director will conduct weekly care plan audits. • **Any abuse allegations are immediately reviewed and investigated.** Staff Education • Staff completed Elder Abuse Training. • Staff completed Redirection Dementia Resident Training. • Monthly Elder Abuse training will be conducted to ensure staff understand protocols for any suspected allegations of abuse. See Attached Completion Date 2/17/26	
Y 0850 SS= J	NAC 449.274 and R043-22 **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.** 1. If a resident of a residential facility becomes ill or is injured, the resident's	Y 0850	Immediate Corrective Action •□□□□□□□□Employee #1 was immediately suspended, removed from the schedule and terminated following investigation. •□□□□□□□□Resident #1received medical evaluation, X-ray imaging, fracture	02/17/2026

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	physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any		related needs, pain management protocols, safety precautions, mobility assistance and supervision. Completion Date:12/02/25 Corrective Acton to Prevent Reoccurrence •□□□□□□□□The Administrator conducted performance review of direct care staff. •□□□□□□□□Residents were assessed for signs of injury, abuse and neglect by the Wellness Director and the Wellness Coordinator. •□□□□□□□□Supervisory rounds were increased on all shifts. •□□□□□□□□New Wellness Director has 20 years' experience working with Dementia and Alzheimer's residents. •□□□□□□□□The Administrator has completed the requirements of National Council of Certified Dementia Practitioners. See attached Systematic Changes The facility reviewed its Abuse and Emergency Response Policy to require: 1. Reinforce "Call 911First" for any abuse that is witnessed, a resident experiences significant injury, a fall	

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	instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on document review, record review and interview, the facility failed to immediately contact emergency services for a resident who was physically abused by a staff member resulting in injury of 1 resident (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 10/20/25, with a diagnosis of dementia. A Facility Incident Report dated 12/01/25 documented on 11/30/25 at 6:50 PM an		results in severe pain or suspected fracture. 1. Implement a mandatory 90-Minute notification window for: •□□□□□□□□ Family •□□□□□□□□ Physician/APRN •□□□□□□□□ Administrator •□□□□□□□□ APS/Police as required by statute 2. All staff were updated and reviewed on changed policy. Staff Training 02/17/26 Mandatory Reporter Retraining All employees completed mandatory education: •□□□□□□□□ Abuse prevention training. •□□□□□□□□ Mandatory reporter law review. •□□□□□□□□ Scenario-based drills (e.g., dementia redirection that included training on calling emergency medical response, de-escalation and dementia behavior care)	

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	incident occurred between R1 and Employee #1 (E1). The Wellness Coordinator received a call at the end of the evening shift on 11/30/25 at 10:30 PM from Employee #2 (E2) regarding alleged physical abuse to R1. E2 reported E1 yanked R1 by the arm, pushed R1 against the wall and pulled R1's arm backward. The incident went on intermittently for an hour when R1 began kicking E1. Instead of E1 using the techniques received in E1's training, E1 continued to be very forceful with R1. E1 grabbed R1 by R1's leg while R1 was kicking and made R1 fall to the ground and then began to drag R1 with R1's left arm and R1's legs trying to force R1 to get up. R1 continued to resist. The incident report lacked documented evidence that the facility called police or an ambulance after staff witnessed E1 physically abusing R1 causing R1 to fall and scream out in pain. R1's Advanced Practice Registered Nurse (APRN) documented a call from the Facility on 11/30/25 reporting R1 had an unwitnessed fall. No apparent injuries and no new orders at this time. A text message dated 12/01/25 at 9:12 AM from the Wellness Coordinator to R1's APRN documented the facility needed an x-ray on R1's left arm as R1 was in pain when R1 tried to move R1's left arm. The APRN ordered an x-ray on 12/01/25. Physician's Order dated 12/01/25 documented an order for R1's left arm to be X-rayed. An email dated 12/02/25 at 3:25 PM from R1's APRN to a mobile x-ray company requested an x-ray technologist try again to take an x-ray of R1's left arm. An email dated 12/02/25 at 5:39 PM from the Administrator of the Mobile x-ray company to R1's APRN documented they attempted to x-ray R1 on 12/02/25, but R1 was unable to comply despite multiple attempts. Reported another technician would be dispatched on 12/03/25 to obtain		•□□□□□□□□ Communicated zero-tolerance abuse policy, signed acknowledgement from staff and reiterated immediate termination for any substantiated abuse. See Attached Completion Date: 02/17/26 Wellness Director andCoordinator received corrective coaching on: • Immediateescalation requirements. • Supervisoryresponsibilities • Interpretation ofhearsay vs. required action. Strengthening Incident Reporting Infrastructure New real-time reportingapplication Implemented for incident alerts. Incident reports cannot besubmitted without: • FullDescription • NotificationLog • CareProvided • Supervisorsign-off	

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	an x-ray of R1's left shoulder. Mobile Imaging Radiology Interpretation dated 12/03/25 documented the x-ray of R1's left shoulder revealed an acute comminuted nondisplaced fracture of the surgical neck was noted and diffuse osteopenia was seen. Impression was noted as an acute fracture of the surgical neck. Adult Protective Services (APS) Referral documented on 12/03/25 a Social Worker visited the facility regarding E1 physically assaulting R1. The Social Worker documented that the Wellness Director reported a police report had not been filed due to E1 no longer being onsite and E1 no longer being an immediate threat to R1. Police Report #25-2145 dated 12/03/25 at 1:47 PM documented a Police Officer was dispatched to the facility regarding elder abuse. Dispatch advised the Police Officer that a staff member had been abusive towards a resident resulting in injury. The police report documented the victim (R1) was seated in a common area after dinner and resisted being moved to their room. The following actions were taken by the suspect (E1): E1 forcefully pulled R1 by pants and arm from chair and then pushed (R1) against the wall, bent arm back behind their back and escorted R1 to their room. R1 kicked E1 and E1 grabbed R1's leg midair, causing R1 to fall hard on their left side. R1 screamed in pain and E1 attempted to drag R1 by the arms when another staff member assisted afterward. Video Surveillance reviewed by a Detective on 12/11/25 documented the following events occurred on 11/30/25: On Main Street of the facility, E1 was seen approaching R1. E1 began to say something to R1, but it is unknown what was said. E1 placed their right hand on R1's		Monitoring • The Administratorwill review incident reports daily. • The WellnessDirector will perform weekly audits of 10% of residents with recent incidents. • Noncompliancewill trigger retraining. • Monthly inservices on elder abuse will be conducted by our Wellness Director with theteam. • New hires ElderAbuse training is done on first day of hire. • An annual abuseprevention training will continue.	

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	right arm and said something again. R1 appeared to rock forward and R1 looked like R1 was arguing with E1. R1 then grabbed E1's lanyard and E1 pulled it away from R1. E1 then used both hands. E1's hand grabbed around the left shoulder of R1 and E1's right hand on R1's back. E1 then pulls R1 forward and R1 appears to resist and quickly sat back in the chair. E1 then picked up R1 by R1's left arm/shoulder and stood R1 up. E1 then took R1's right hand and grabbed the back of R1's pants. R1 was still holding onto the chair with R1's right hand, and then E1 ripped the chair away from R1 and took R1's right hand off of the chair. R1 then walked toward the closet wall and put R1's hand on it. R1 was then spun around in a circle and E1 then begins to escort R1 into the hallway still holding R1's pants and left arm. The next video showed E1 escorting R1 to R1's room where E1 was briefly out of direct view of the camera. E1 can be heard in the video saying, "Calm down," multiple times. E1's back was seen, E1 took a big step back and R1 was then seen falling to the ground and landing on R1's left shoulder. E1 was clearly holding R1's right leg/foot and then let go. When R1 fell, R1 is heard screaming in what sounds like agonizing pain. R1 then moaned in pain as R1 was lying on R1's back on the ground. E1 then takes R1's right hand with both of E1's hands and attempts to pull R1 upwards by one arm. R1 could not get up from that position and E1 then let go of R1's hand. R1 fell back to the ground, still reeling in pain. E1 then grabs both of R1's hands and again tried to pull R1 upward by R1's arms. R1 was able to get to a seated position at that time. A Medication Technician was then seen entering the camera frame to assist. Multiple staff corroborated abuse; E1 admitted to holding R1's leg for '3 seconds.' The Wellness Director reported that none of the actions taken by E1 were part of the			

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	facility's policies of procedures. The correct procedure would have been to leave the resident sitting and let them be. Staff would then have another Care Partner attempt to assist the resident at a later time or have 2 Care Partners assist with R1. The Medical Records showed injuries consistent with the incident. The Police charged E1 with a felony for battery with substantial bodily harm of a person over 60 years old. On 01/22/25 in the morning, the Administrator reported being informed in the morning of 12/01/25 that E1 had physically abused R1 at 6:50 PM on 11/30/25. According to the Administrator, the facility did not immediately contact 911 because the Aging and Disability Services website instructed them not to if the perpetrator was no longer onsite. The Administrator verbalized E1 had been suspended on 12/01/25 due to the abuse of R1 on 11/30/25. On 12/01/25, the Wellness Director removed E1 from the schedule and immediately began the investigation. E1 had been suspended pending finalization of the investigation. On 01/27/26 at 11:56 AM, Employee #2 (E2) explained on 11/30/25 at 6:50 PM, E1 was trying to get R1 up from the chair and R1 did not want to go with E1. R1 tried to grab the key around E1's neck and E1 said, "We're not doing that today." E1 used all their force to stand R1 up and then pushed R1 to the wall and twisted R1's arm like E1 was going to handcuff R1. E2 was in shock at what they witnessed. Then E1 started walking R1 to their room. E2 was about to call the Wellness Coordinator when E1 asked for an incident report and explained R1 had fallen. E2 then called the Wellness Coordinator later at 8:30 PM and explained to the Wellness Coordinator that they needed to look at the cameras because E2 did not think there was a fall. On 01/27/26 at 12:08 PM, Employee #3			

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(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
	(E3) reported they were facing the wall, performing the evening medication pass on the 200 hall when E3 heard a resident screaming. E3 turned and saw R1 on the floor on their left side and asked if R1 was okay. E3 assessed R1 for injuries and did not see any so E3 assisted R1 up with the assistance of E1. E3 verbalized reporting the fall to the Wellness Coordinator on 11/30/25 after assessing R1 and notifying R1's physician at approximately 7:00 PM. According to E3, on 12/01/25 R1 had bruises on their left shoulder and an Xray was ordered. E3 verbalized being shocked when seeing the bruises on R1. On 01/28/26 at 2:45 PM, the Wellness Coordinator reported on the night of the 11/30/25, first E1 called and reported R1 had fallen, and then E3 called and reported the fall. Later around 8:30 PM, E2 called and verbalized that R1 didn't just fall and then reported what E2 had witnessed between E1 and R1. On 01/28/26 at 2:45 PM, the Wellness Coordinator reported reaching out to the Wellness Director around 9:00 PM or 10:00 PM. The Wellness Director explained they were unavailable and would have to figure the situation out in the morning. The Wellness Coordinator explained they did not immediately notify the Administrator of the alleged abuse per policy because it was hearsay. The following day the Wellness Coordinator and Wellness Director informed the Administrator of the incident, and the Administrator reviewed the video. On 02/04/26 in the afternoon, R1's APRN reported the facility communicated to the provider on 11/30/25 that R1 had an unwitnessed fall with no injuries. R1's APRN advised they were not aware of what occurred between E1 and R1 until a week to two weeks after it occurred. Facility Resident Abuse Policy dated 07/01/019 documented the team must ensure that a resident who has been allegedly abused receives prompt medical attention or other needed services.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11493	A. BUILDING _____ B. WING _____	01/22/2026

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	Severity: 4 Scope: 1 Complaint #12699 and FRI#12663			
Y 0965 SS= F	**NAC 449.2754** **Residential facility which provides care to persons with Alzheimer's disease: Application for endorsement; general requirements.** 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (a) The facility's policies and procedures for providing care to its residents; (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; (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behaviors will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to:	Y 0965	Corrective Action Immediate Schedule Restructuring •□□□□□□□□The facility reviewed staffing schedules and immediately adjusted staffing levels to maintain 1:6 ratio. •□□□□□□□□Additional caregivers and medication technicians were hired. •□□□□□□□□A staffing contingency plan was implemented for callouts. •□□□□□□□□Care staff, which will include the Wellness Coordinator, and the Wellness Director will be available to assist and to have a schedule with residents to provide adequate care. Completion Date:02/17/26 Corrective Action to Prevent Reoccurrence • Staffing and schedules for all shifts have been audited for the past 30 days. The community has met the required 6-1 ratio, and we will continue to do so as we are	02/17/2026

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	(I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; and (d) The criteria for admission to and discharge and transfer from the facility. 4. The written statement required pursuant to subsection 3 must be available for review by residents of the facility, members of the staff of the facility, visitors to the facility and the bureau. 5. The administrator shall ensure that the facility complies with the provisions of the statement required pursuant to subsection 3. 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. Findings include: On 11/30/25 the census at the facility was 58 residents. The facility needed ten Medication Technicians (Med Techs)/Care Partners to meet the required one staff to six resident ratio. A review of the staff schedule revealed, the morning shift consisted of eight Med Techs/Care Partners, and the facility was short staffed by two Med Techs/Care Partners. The afternoon shift consisted of eight Med Techs/Care Partners, and the facility was short two Med Techs/Care Partners. On 02/06/26 in the morning, the Administrator acknowledged the facility did not meet the one staff to six resident ratio on the evening of 11/30/25. Severity: 2 Scope: 3		consistently hiring new team members to ensure compliance. See attached • Any shifts not meeting ratios will be documented and corrected immediately by Wellness Director and Wellness Coordinator having a schedule with residents providing them with adequate care according to their care plan. • Overview of daily census, staffing ratio and call outs are reviewed at daily stand-up meetings. The facility will implement the above corrective actions to ensure compliance with the NAC449 regulations.	

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	This is a repeat deficiency from the 06/26/25 survey.			