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 _____	**03/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON ASSISTED LIVING LLC	**550 NORTH SHERMAN ST., FALLON, NEVADA ,89406**

(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 survey conducted at your facility on 03/27/2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 37 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category II residents. The census at the time of the survey was 28. Five resident files were reviewed There were two complaints investigated: Complaint #NV00073067 with the allegation the facility failed to report an allegation of sexual abuse was substantiated (See Y556). The following allegations could not be substantiated due to a lack of evidence: -Allegation #1: A resident was allowed to remain in the facility despite requiring a higher level of care. -Allegation #2: A resident was neglected, resulting in emotional harm -Allegation #3: A resident was not protected from resident-to-resident sexual abuse. Complaint #NV00073333 with the allegation in-room garbage cans were not emptied frequently enough to prevent offensive odors could not be substantiated due to a lack of evidence. An investigation into the allegations included: Observations were performed of residents in the common areas, residents in bedrooms, cleanliness of the facility, a housekeeper emptying trash cans, in-room trashcans, and resident to resident interactions. Interviews were conducted with two residents, a housekeeper, a medication technician, and the Administrator. Review of resident records included admission dates, diagnoses, physician names, progress notes, physician placement determinations, annual physicals, service plans, and activities of daily living assessments. Document review included the housekeeper job description and an internal incident report. Review of facility policies included	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: HEATHER DEITRICK Title: Administrator Date: 05/01/2025

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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	residency criteria, residents' rights, and abuse. 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:			
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. Inspector Comments: Based on interview and document review, the facility failed to ensure an allegation of resident-to-resident sexual abuse was reported to the State Agency (SA) per facility policy for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 05/27/2024, and discharged on 12/28/2024, with diagnoses including metabolic encephalopathy, chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. Resident #2 Resident #2 was admitted to the facility on 03/01/2024, with a diagnosis of Lewy Body Parkinsons disease. A progress note dated 12/26/2024, documented a Medication Technician was exiting the medication storage room when Resident #1 used their call light. Resident #2 was observed without pants, leaving Resident #1's bedroom. Resident #1 seemed "very upset and began hollering." Resident #1 informed the Medication Technician Resident #2 attempted to get into bed with Resident #1 and Resident #2	0556	1) How you will correct the specific finding (s) stated in the Statement of Deficiencies. Campus administrator will -in-service administrator on Abuse policy 1.31. 2) What measures or systematic changes will be put into place to ensure the deficient practice does not recur. Yearly in servicing on elder abuse will be completed for all staff. 3) How will the corrective action be monitored to ensure the deficient practice will not recur. Monitor Elder abuse training by utilizing a compliance worksheet. 4) The title of the person responsible for ensuring the plan of correction is implemented. Administrator and/or resident service director. 5) The date the corrective action be completed. 5/1/25	05/01/2025

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	stated "all (the resident) needed was a man." Resident #1 requested a written statement be completed and asked for an anxiety medication from the Medication Technician. On 03/27/2025 at 1:22 PM, a Medication Technician defined sexual abuse as touching a resident where the resident should not be touched or being in a resident's room without the resident's permission. The Medication Technician verbalized the Administrator was the facility's abuse coordinator. On 03/27/2025 at 1:26 PM, the Administrator explained the facility did not complete an investigation into the incident or an incident report for Resident #1 because Resident #1 was removed from the facility the day after the incident. On 03/27/2025 at 2:19 PM, the Administrator defined abuse as intentionally inflicting harm on a resident. Sexual abuse was a type of abuse and occurred when an individual acted sexually toward an unwilling recipient. The Administrator explained the Administrator would notify the authorities "depending on the type of abuse" to have occurred. The Administrator explained the Administrator was unable to complete a statement from Resident #1 so was unsure whether the resident perceived the incident to be sexual or abusive. On 03/27/2025 at 3:05 PM, the Administrator confirmed the progress note acted as a statement from Resident #1 and would be considered an allegation of abuse. The Administrator verbalized the allegation was not reported to the SA but should have been. The facility policy titled, "Abuse," revised 05/2010, documented the SA would be notified of any incident involving alleged abuse or neglect. Severity: 2 Scope: 1 Complaint #NV00073067			