STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11545	A. BUILDING _____ B. WING _____	11/17/2025

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
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 investigation and annual survey completed at your facility on 11/17/2025. The facility is licensed for 37 Residential Facility for Group beds for elderly and disabled persons and/or assisted living, Category II residents. The census at the time of the survey was 26. Ten resident files and ten employee files were reviewed. The facility received a grade of D. There was one complaint investigated. Complaint #NV00074838 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of grooming and physical appearance for residents, the cleanliness of resident rooms and common areas, trash disposal, and residents participating in activities. Interviews were conducted with residents, Housekeepers, and the Resident Services Director. Clinical Record Review of five records which included the residents of concern. Document Review included facility policy and procedures.			
Y 0053 SS= D	**NAC 449.194**	Y 0053	1) How you will correct the specific finding (s) stated in the statement of deficiencies. Residents # 5 & #7 are longer a resident of assisted living. 2) What measures or systematic changes(s)	02/01/2026

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	4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review and interview, the Administrator failed to ensure resident records were complete for 2 of 10 sampled residents (Resident #5 and #7). Findings include: Resident #5 Resident #5 was admitted to the facility on 05/24/2024, with diagnoses including atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, cerebrovascular accident, and essential hypertension. Resident #7 Resident #7 was admitted to the facility on 12/19/2024, with diagnoses including acute kidney failure, cognitive communication deficit, pain, and muscle weakness. On 11/17/2025 at 1:43 PM, the Resident Services Director verbalized Resident #5 and #7 had been receiving home health services related to skin issues. The Resident Services Director could not verbalize the name or contact information for the home health agencies providing care to Resident #5 and #7. Resident #5 and #7's records lacked documentation of a home health care plan, the name and contact information of the home health agency, or the type of home health services the resident had been receiving. On 11/17/2025 at 1:44 PM, the Administrator confirmed Resident #5 and #7 had been receiving home health services but had not collected or documented the name or contact information of the home health agencies, or received current home health care plans, or documentation of the		will be put into place into place to ensure the deficient practice does not recur. Resident requiring home health service will have a binder that will include the following: Name and contact information of the home health agency, current health plan of care, or documentation of the type of services the resident is receiving. 3) How the corrective action will be monitored to ensure the deficient practice will not recur. Administrator and/or resident Service Director will monitor to ensure resident have required information regarding home health services. 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 will be completed. 2/1/2026	

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	type of services the residents had been receiving. The Administrator verbalized the home health providers were required to sign in and out of the facility's visitor log but had not required them to provide any documentation related to resident care. Severity: 2 Scope: 1			
Y 0104 SS= D	**NAC 449.200** **Personnel files** (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on employee record review and interview, the facility failed to ensure 2 of 10 employees obtained fingerprints and a background check clearance per the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #3 and #4). Findings include: Employee #3 Employee #3 was hired as a Resident Assistant on 09/29/2025. Employee #3's record lacked documentation fingerprints had been obtained and submitted, and a background check clearance had been completed. Employee #4 Employee #4 was hired as a Medication Technician/Resident Assistant on 06/18/2025. Employee #4's record lacked documentation fingerprints had been	Y 0104	1) How you will correct the specific finding (s) stated in the Statement of deficiencies. Employees #3 & #4 will have background and fingerprints completed. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recure. New employees will have fingerprints/background checks completed as part of their hire process. 3) How the corrective action will be monitored to ensuring the plan of correction is implemented. Compliance worksheet will be used to track needed new hire and annual requirements for employment. 4) The title of person(s) responsible for ensuring the plan of correction is implemented. Administrator and/or resident Service Director. The date corrective action be implemented. 1/20/2026	01/20/2026

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	obtained and submitted, and a background check clearance had been completed. On 11/17/2025 at 12:00 PM, the Administrator verbalized all background checks were to be completed upon hire. On 11/17/2025 at 1:30 PM, the Human Resources Director confirmed Employee #3 started as a Resident Assistant on 09/29/2025 and had not yet obtained fingerprints for submission for a background check and Employee #4 started on 06/18/2025 and had not yet obtained fingerprints for submission for the background check. The Human Resources Director verbalized having been aware of the background check requirements for employees. Severity: 2 Scope: 1			
Y 0102 SS= E	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on employee record review and interview, the facility failed to ensure annual tuberculosis (TB) screenings had been appropriately completed for 1 of 10 sampled employees (Employee #8), pursuant to Nevada Administrative Code, Chapter 441A.375 and initial physical were complete upon hire for 2 of 10 sampled employees (Employee #4 and #9). Findings include: TB Test Employee #8 Employee #8 was hired as a Resident Assistant on 03/07/2023. Employee #8's record documented an	Y 0102	1) How will you correct the specific finding (s) stated in the Statement of Deficiencies. Employee #8 in no longer an employee. Employees # 4 &#9 will have physical exams completed and put into their personal files. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur. New employee will have physical exams completed prior to starting employment. Employees will have TB test completed annually. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur. A list of mandatory items needed prior to employment will be completed by administrator and/or designee. Compliance sheet will be utilized to ensure annual classes; tests are completed on time. 4) The title of the person responsible for ensuring the plan of correction is implemented. Administrator and resident service director. 5) The date the corrective action be completed. 1/21/2026	01/21/2026

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	annual one-step TB test administered on 01/14/2025; however, lacked a date the TB test was read. On 11/17/2025 at 12:00 PM, the Resident Services Director (RSD) explained a TB test required an administered date and a read date to be valid. The RSD confirmed Employee #8's annual TB test lacked a read date, rendering the test invalid. Physicals Employee #4 And I changed to: Employee #4 was hired as a Medication Technician/Resident Assistant on 06/18/2025. Employee #4's record lacked documented evidence of a physical completed on or before hire. Employee #9 Employee #9 was hired as a Resident Assistant on 02/27/2025. Employee #9's record lacked documented evidence of a physical completed on or before hire. On 11/17/2025 at 12:00 PM, the Administrator explained the Human Resources Director was responsible to ensure all physicals were completed upon hire. The Administrator confirmed Employee #4 and #9's records lacked documented evidence of a physical being completed upon hire. Severity: 2 Scope: 2			

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Y 0106 SS= D	NAC 449.0113 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 personnel record review and interview, the facility failed to ensure Cardiopulmonary Resuscitation (CPR) retraining was completed timely for 1 of 10 sampled employees (Employee #7). Findings include: Employee #7 Employee #7 was hired as a Medication Technician/Resident Assistant on 10/24/2023. Employee #7's record documented initial CPR training expired on 01/2025, and lacked documented evidence of retraining completed. On 11/17/2025 at 12:00 PM, the Administrator confirmed Employee #7's CPR had expired in January 2025. Severity: 2 Scope: 1	Y 0106	1) How will you correct the specific finding stated in the statement of deficiency. Employee # 7 will take the CPR class on 11/24/2025. 2)What measures are systematic changes will be put into place to ensure deficient practice does not recur. CPR certifications will be monitored use a spreadsheet to keep track of training due dates. 3)How will the corrective action be monitored. Resident service director will utilize a spreadsheet to track training. 4) The title of person responsible for implementing plan of correction. Resident service director. 5) Date the corrective action be completed. 11/20/2025	11/20/2025
Y 0172 SS= D	NAC 449.209 2. Containers used to store garbage	Y 0172	1) How you will correct the specific findings stated in the Statement of Deficiencies. Outside garage receptacle will be kept clean of debris and any unknown substances. 2) What measures or systematic change will	01/20/2026

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	outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.		be put into place to ensure the deficient practice does not recure. Outside garbage will be cleaned in a timely manner when items are on the ground. 3) How the corrective action will be monitored to ensure the deficient practice does not recure. Area will be monitored by staff daily. 4) The person responsible for ensuring the plan of correction is implemented. Administrator and/or designee. 5 1/17/2025	

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	Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure the outside garbage receptacles were free of debris on the surrounding pavement. Findings include: On 11/17/2025 at 9:51 AM, a garbage receptacle outside was surrounded on left side and back with debris including lint and leaves. In the center of the gated garbage receptacle areas were disposable gloves and used paper towels. There was an unknown substance light in color on the pavement at the entrance to the garbage receptacle area. On 11/17/2025 at 9:51 AM, the Dietary Supervisor (DS) explained all staff were responsible for ensuring the garbage receptacle area outside was kept clean. The DS confirmed the unkempt garbage receptacle area and explained it should be kept clean to prevent rodents and bugs and to ensure disposed of food was inaccessible to residents. The facility policy titled “Disposal of Garbage and Refuse,” undated, documented the surrounding areas of refuse containers and dumpster would be kept clean to ensure the accumulation of debris and insect or rodent attractions were minimized. Severity: 2 Scope: 1			
Y 0250 SS= D	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or	Y 0250	1) How you will correct the specific finding (s) stated in the statement of deficiencies. Dietary manager put in a work order at 7:33, November 17,2025 to have the handle fixed by Highland Village maintenance department. 2)What measures or systematic changes will be put into place to ensure the deficient practice does not recure. Dietary manager to oversee kitchen equipment. 3) How will the corrective action be monitored to ensure deficient practice does not recur. Kitchen staff and dietary manager	11/17/2025

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	less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation and interview, the facility failed to ensure kitchen equipment was in working order. Findings include: On 11/17/2025 at 9:44 AM, facility staff started a cycle on the high temperature dishwasher in the main facility kitchen. Hot water sprayed out of the holes where the handle was attached to the dishwasher door. On 11/17/2025 at 9:44 AM, the Dietary Supervisor (DS) verbalized the dishwasher handle had been fixed multiple times before; however, each time the handle was fixed, it would loosen quickly after. The DS explained the water spraying out of the dishwasher handle could present a safety hazard to facility staff. Severity: 2 Scope: 1		will supervise all equipment. 4)The title of person responsible to ensure plan of correction is implemented. Dietary supervisor. 5) Date of corrective action. 11/17/2025	
Y 0522 SS= D	NAC 449.259	Y 0522	1) How will you correct the specific finding (s) stated in the Statement of Deficiencies. Facility will develop a complete person-	01/22/2026

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	(k) If the resident has Alzheimer's disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility, including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if: (I) It is determined through an assessment conducted pursuant to paragraph (c) of subsection 1 of NRS 449.1845 that the resident meets the criteria prescribed in paragraph (a) of subsection 2 of that section; and (II) The facility does not meet the requirements of NAC 449.2754 or 449.2756 or is otherwise unable to properly care for the resident. Inspector Comments: Based on record review, document review and interview, the facility failed to develop a complete person-centered service plan for a resident with a dementia diagnosis (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/17/2024, with a diagnosis of dementia. Resident #1's service plan dated 04/17/2025, lacked documentation of the following: -the manner in which the resident's behaviors would be managed. -the steps the facility would take to prevent the resident from wandering from the facility and how the facility would respond if the resident did so. -the criteria and provisions for the resident to be transferred or discharged from the facility if the facility did not meet the		centered service plan for resident #1. 2) What measures or systematic change(s) will be put into place to ensure deficient practice does not recur. Service plans will be revised to reflect "Person-Centered" service plan. 3) How the corrective action will be monitored to ensure the deficient practice will not recur. Service plans will be reviewed annually. 4) The title and person(s) responsible for ensuring the plan of correction is implemented. Administrator and Resident Service Director 5) The date the corrective action be completed. 1/22/2026	

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	requirements to care for or were unable to property care for a resident with dementia. On 11/17/2025 at 1:12 PM, the Administrator confirmed Resident #1's service plan dated 04/17/2025 was not complete and lacked specific documentation related to the resident's dementia diagnosis. The Administrator confirmed the facility's service plan policy lacked documentation of all the required information to be included in the service plan. The facility policy titled, "Service Plan," revised 04/2010, documented the service plan would include the level of service the resident would be receiving, but lacked documentation of the requirements of the management of behaviors from a resident with dementia, the steps taken to prevent and how to respond to a resident wandering from the facility, and the criteria and provisions for transfer or discharge if the facility did not meet the requirements to care for or were unable to property care for a resident with dementia. Severity: 2 Scope: 1			
Y 0515 SS= F	NAC 449.259 **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	Y 0515	1) How you will correct the specific finding (s) stated in the Statement of Deficiencies. Residents will have service plans updated to reflect "Person-Centered" 2)What measures or systematic changes will be put into place to ensure the deficient practice does not recur. Service plans will be reviewed annually. 3) How the corrective action be monitored to ensure deficient practice does not recur. Service plans will be reviewed annually. 4) Title of person responsible for plan of correction being implemented. Administrator and Resident Service Director 5 The date the corrective action be completed. 3/1/2026	03/01/2026

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	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 or her interests and capacities; Inspector Comments: Based on record review, document review and interview, the facility failed to develop complete person-centered service plans for 10 of 10 sampled residents. Findings include: On 11/17/2025, during resident record review, service plans for 10 of 10 sampled residents lacked the following:			

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	-the type of protective supervision necessary for each resident. -the manner in which caregivers would be informed of the type of protective supervision for each resident. -the permission to leave and enter the facility, and physical and mental capabilities for each resident do so. -the manner in which each resident's clothes were to be cleaned. -the steps to inform how each resident's valuables would be protected. On 11/17/2025 at 1:03 PM, the Administrator confirmed the resident's service plans were not complete and the facility's service plan policy lacked documentation of all the required information to be included in the service plans. The facility policy titled, "Service Plan," revised 04/2010, documented the service plan would include the level of service the resident would be receiving, but lacked documentation of the requirements of protective supervision, leaving and entering the facility, how clothes were to be cleaned, or how resident valuables would be protected. Severity: 2 Scope: 3			

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Y 0450 SS= D	**NAC 449.231** **First aid and cardiopulmonary resuscitation.** 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1 of 10 sampled employees acquired cardiopulmonary resuscitation (CPR) training within 30 days of hire. (Employee #4). Findings include: Employee #4 Employee #4 was hired as a Medication Technician/Resident Assistant on 06/18/2025. Employee #4's personnel record documented CPR training dated 07/23/2025, beyond 30 days of hire. On 11/17/2025 at 12:00 PM, the Administrator verbalized CPR training was supposed to be done within 30 days of hire. The Administrator confirmed Employee #4's personnel record documented CPR training was completed beyond 30 days of hire. Severity: 2 Scope: 1	Y 0450	1) How you will correct the specific finding (s) stated in the statement of deficiencies. Employees will complete CPR withing 30 days of hire. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur. Employees will be signed up for CPR upon hire. 3) How the corrective action will be monitored. It will be monitored by utilizing a check list. 4) The title of person responsible for ensuring plan of correction is implemented. Administrator and Resident Service Director. 5) The date the corrective action will be completed. 1/1/2026	01/01/2026
Y 0920 SS= D	**NAC 449.2748**	Y 0920	1) How will you correct the specific finding stated in the statement of deficiencies. Resident #10 will have the medication	01/20/2026

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	Medication Storage. 1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on record review, medication review and interview, the facility failed to ensure an over-the-counter medication was labeled with the resident		labeled and on medication cart. 2) What measures or systematic changes will be put into place to ensure the deficient practice. Medication cart audits will be completed monthly. 3) How will the corrective action be monitored to ensure the deficient practice does not recur. Monthly cart audits will be completed. 4) The title of person responsible for ensuring the plan of correction is completed. Administrator and/or Resident Service Director. 5) The date the corrective action be completed. 1/20/2026	

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	and physician names for 1 of 10 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 05/23/2025, with diagnoses including dementia, atrial fibrillation and hyponatremia. A physician order dated 07/02/2025, documented acetaminophen tablet, 500 milligrams (mg), take one tablet by mouth every four hours as needed for pain. On 11/17/2025 at 2:30 PM, the acetaminophen bottle located in the medication cart for Resident #10, lacked a label documenting the resident's name and the name of the physician who ordered the medication. On 11/17/2025 at 2:30 PM, the Resident Services Director confirmed the acetaminophen bottle was for Resident #10 and the physician order was to administer as needed for pain. The Resident Services Director confirmed the medication bottle should have had a label documenting the resident and physician names but did not. Severity: 2 Scope: 1			
Y 0890 SS= B	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.** 1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery;	Y 0890	1) How will you correct the specific finding (s) stated in the statement of deficiencies. Medication Technician will be in-served on medication policies and procedures. 2) What measures or systematic changes will be put into place to ensure deficient practice does not recur. Audits of the MARS will be conducted. 3) How the corrective action will be monitored to ensure the deficient practice does not recure. On going education and audits will be conducted. 4)The title of the person(s) responsible for ensuring the plan of correction is implemented. Administrator and Resident Service Director. 5) 01/21/2026	01/21/2026

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	(3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication. Inspector Comments: Based on record review and interview, the facility failed to			

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	ensure a resident's medication administration record (MAR) accurately documented a physician's order for 1 of 10 sampled residents (Resident #8) and the MAR was completed and accurate for 3 of 10 sampled residents (Resident #3, #6, and #7). Findings include: Physician Orders Resident #8 Resident #8 was admitted to the facility on 06/06/2024, with diagnoses including chronic obstructive pulmonary disease, heart disease, chronic kidney disease, and hypertension. Resident #8's November 2025 MAR documented the following: -Amlodipine Besylate 5 milligram (mg) tablet, give two tablets by mouth one time a day. A Physician's order dated 04/01/2025, documented Amlodipine 10 mg tablet. Take one tablet by mouth daily. Resident #8's medications on-site contained Amlodipine 10 mg tablet. Take one tablet by mouth daily. On 11/17/2025 at 2:10 PM, the Resident Services Director (RSD) confirmed Resident #8's Amlodipine was incorrectly documented on the resident's MAR. The RSD was unable to correctly explain how the resident was receiving the dose of medication. Initialed MAR Resident #3 Resident #3 was admitted to the facility on 11/08/2024, with diagnoses including depression, hypertension, and history of alcohol abuse. Resident #3's November 2025 MAR			

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	documented the following medication lacked being initialed by the Medication Technician (MT) November 8th, 13th and 14th 2025. -Xarelto 10 mg tablet, take one tablet by mouth once daily for active history of pulmonary embolism. Resident #6 Resident #6 was admitted to the facility on 08/22/2025, with diagnoses including respiratory failure, atrial fibrillation and hypertension. Resident #6's November 2025 MAR documented the following medication lacked being initialed by the MT November 4th, 6th and 9th 2025. -Levothyroxine 200 microgram (mcg) tablet, take one tablet by mouth once daily. -Methocarbamol 500 mg tablet, take two tablets by mouth every six hours. -Spiriva Aerosol 1.25 mcg, inhale two puffs by mouth twice daily. -Venlafaxine 75 mg capsule, take once capsule by mouth once daily. -Venlafaxine 150 mg capsule, take one tablet by mouth once daily. -Advair 250-50 mcg inhaler, inhale one puff by mouth twice daily. Resident #7 Resident #7 was admitted to the facility on 02/19/2024, with diagnoses including acute kidney failure, cognitive communication deficit and muscle weakness. Resident #7's November 2025 MAR documented the following medication lacked being initialed by the MT November 3rd and 4th 2025. -Docusate calcium 240 mg capsule, take one capsule by mouth once daily. -Tamsulosin hydrochloride (HCl) 0.4 mg capsule, take one capsule by mouth once daily. -Polyethene Glycol powder, mix one pack 12 gm with 8 ounces of liquid of choice every day for constipation. -Sertraline HCl 50 mg tablet, take one tablet by mouth once daily.			

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	-Atorvastatin 40 mg tablet, take one tablet by mouth at bedtime. On 11/17/2025 at 1:09 PM, the RSD confirmed Resident #3, #6, and #7's MARs lacked documented evidence of the resident's medications being initialed by the Medication Technician in the resident's November 2025 MAR and the RSD was unable to determine if the medication was administered to the resident. Severity: 1 Scope: 2			
Y 0883 SS= D	NAC 449.2742 7. If a resident refuses, or otherwise misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident's record had documented evidence a physician was notified after a resident missed an ordered dose of medication for 1 of 10 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 08/22/2025, with diagnoses including depression, atrial fibrillation, anxiety disorder and pulmonary hypertension. A Discharge Note dated 08/22/2025, documented Resident #6 was to continue taking the following medications: -Eliqus 5 milligram (mg) tablet, take one tablet by mouth twice daily. -Furosemide 40 mg tablet, take one tablet by mouth once daily. -Gabapentin 100 mg capsule, take one capsule by mouth at bedtime. -Levothyroxine 200 microgram (mcg) tablet, take one tablet by mouth every morning.	Y 0883	1) How you will correct the specific finding (s) stated in the statement of deficiencies. "Refused/Missed Medication" form will be implemented. 2) What measures or systematic change(s) will be implemented to ensure the deficient practice does not recur. Medication technician will be in-served on "Medication Missed " form. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur. "Refused/Missed Medication form will be used to inform Doctor. 4) The title of person(s) responsible for ensuring the plan of correction is implemented. Administrator and Resident Service Director. 5) The date the corrective action will be completed. 1/21/2026	01/21/2026

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	-Loratadine 10 mg tablet, take one tablet by mouth one daily. -Metoprolol Succinate extended release 100 mg tablet, take one tablet by mouth twice daily. -Spiriva Respimat Inhalation Aerosol Solution 1.25 mcg, inhale 2 puffs by mouth twice daily. -Trazadone 150 mg tablets, take one tablet by mouth at bedtime. -Venlafaxine extended release 75 mg tablet, take one tablet by mouth once daily. Resident #6's record lacked documented evidence the physician was notified of the resident not receiving prescribed medications as ordered from 10/30/2025 – 11/04/2025. On 11/17/2025 at 2:25 PM, during a review of Resident #6's medications and in the presence of the Resident Services Director (RSD), the November Medication Administration Record, documented Medication Technician initials with a circle around them 11/1/2025 – 11/04/2025. The RSD verbalized the initials with a circle around them indicated the medication was not given as it was not on site, and there was not documented evidence the physician was notified of missed medications administrations as prescribed. Severity: 2 Scope: 1			
Y 0878 SS= E	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written	Y 0878	1) How will you correct the specific finding stated in the statement of deficiencies. Resident # 5 has expired. Residents #3 & #4 have OTC in house. 2) What measures or systematic changes will be put into place to unsure deficient practice does not recur. Medication Technicians will be in-serviced on the following policies: Person Centered Medication Administration & Medication Administration policies. 3) How the corrective action will be monitored to ensure the deficient practice does not recure. Medication audits will be conducted to ensure medication are on site. 4) The title of person(s) Administrator and/or resident service director.	11/20/2025

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	instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review, medication review and interview, the facility failed to ensure over-the-counter medications were on site and available to		5) Date 11/20/2025	

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	administer per the physician order for 2 of 10 sampled residents (Resident #4, #5 and #3). Findings include: Resident #4 Resident #4 was admitted to the facility on 04/20/2022, with diagnoses including chronic obstructive pulmonary disease, essential hypertension, diabetes mellitus, and urinary incontinence. A physician order dated 03/08/2024, documented loperamide, two milligram (mg) tablet, take one tablet by mouth four times a day as needed for diarrhea. On 11/17/2025 at 2:19 PM, the medications for Resident #4, located in the medication cart, did not contain the prescribed over-the-counter loperamide. On 11/17/2025 at 3:01 PM, the Resident Services Director (RSD) confirmed the loperamide medication was not on site and available to administer per the physician order for Resident #4. The RSD verbalized not having been sure if the medication had been ordered. Resident #5 Resident #5 was admitted to the facility on 05/24/2024, with diagnoses including atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, cerebrovascular accident, and essential hypertension. A physician order dated 03/21/2025, documented melatonin, five mg tablet, take one tablet by mouth at bedtime as needed for insomnia. On 11/17/2025 at 2:23 PM, the medications for Resident #5, located in the medication cart, did not contain the prescribed over-the-counter melatonin. On 11/17/2025 at 3:02 PM, the RSD confirmed the melatonin medication was not			

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	on site and available to administer per the physician order for Resident #5. The RSD verbalized not having been sure if the medication had been ordered. Resident #3 Resident #3 was admitted to the facility on 11/08/2024, with diagnoses including hypertension and depression. A physician's order dated 04/03/2025, documented sennosides 8.6 mg tablet, take one tablet by mouth once a day as needed for constipation. A physician order dated 09/02/2025, documented lactobacillus acidophilus and bulgaricus oral tablet, take one tablet by mouth every day. On 11/17/2025 at 2:25 PM, during a review of Resident #3's medications, the Senna and Acidophilus were not present. On 11/17/2025 at 2:30 PM, the RSD confirmed the medications were listed on the resident's MAR; however, were not included among Resident #3's medications. The RSD explained the Med Techs were responsible for requesting medication refills from the pharmacy seven days prior to the expected last administration. Severity: 2 Scope: 2			
Y 1810 SS= C	**NAC 449.0109** **Program and policy for control of infection; designation and training of person responsible for infection control. (NRS439.200, 449.0302)** 1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection	Y 1810	1) How you will correct the specific finding stated in the Statement of Deficiencies. Administrator will review facility Infection Control Plan annually. 2) What measures or systematic changes will be put into place to ensure the deficient practice does not recur. Administrator and Resident Service Director will review Infection Control Plan and Emergency Preparedness plan annually. 3) How will the corrective action be monitored. Administrator to monitor infection Control Plan 4) The title of the person(s) responsible for ensuring plan of correction is implemented. Administrator and Resident Service Director	01/22/2026

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	11545	A. BUILDING _____ B. WING _____	11/17/2025

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

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	control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and (c) Develop and carry out a comprehensive plan for emergency preparedness. 2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on observation, document review and interview, the Administrator failed to ensure the facility's Infection Control Program was reviewed annually. Findings include: On 11/17/2025 at 12:00 PM, the facility's Infection Prevention and Control Plan, undated, was provided by the Administrator. The Infection Prevention and Control Plan		5)Date: 1/22/2026	

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	documented the plan was last reviewed on 02/15/2024; however, lacked documented evidence the plan was reviewed annually. On 11/17/2025 at 12:00 PM, the Administrator verbalized the Infection Control Plan and policies were to be reviewed yearly. The Administrator confirmed the plan lacked documented evidence of being reviewed annually. Severity: 1 Scope: 3			
Y 1540 SS= D	**NAC 449.011931and R004-24** NAC 449.011931 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep	Y 1540	1) How will you correct the specific finding (s) stated in the Statement of Deficiencies. Employee #4 will take Cultural Competency on 11/21/2025. #6 is no longer employed. 2)What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur. Personal file check list will be used to ensure training is completed. 3) How the corrective action(s) be monitored to ensure deficient practice does not recur. Utilizing personal file checklist. 4) The title of person(s) responsible for ensuring plan of correction is implemented. Administrator and Resident Service Director 5) 1/21/26	01/21/2026

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	documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on interview, personnel record review, and document review, the facility failed to ensure initial cultural competency training was completed within 90 days of hire for 2 of 10 sampled employees (Employee #4 and #6). Findings include: Employee #4 Employee #4 was hired as a Medication Technician/Resident Assistant on 06/18/2025. Employee #4's personnel record lacked documentation of completed cultural competency training. Employee #6 Employee #6 was hired as a Medication Technician/Resident Assistant on 06/19/2025.			

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	Employee #6's personnel record lacked documentation of completed cultural competency training. On 11/17/2025 at 12:00 PM, the Administrator verbalized all employees were required to complete cultural competency training within 90 days of hire. The Administrator confirmed Employee #4 and #6 lacked completed cultural competency training. Severity: 2 Scope: 1			