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 _____	05/11/2026

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 mandatory regrading survey completed at your facility on 05/11/2026. 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 31. Six resident files, three closed resident records and six employee files were reviewed. The facility received a grade of B. There was one complaint investigated. Complaint #NV00074632 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of medication administration and medication cart audit. Interviews were conducted with residents, Medication Technician, the Resident Services Director and Administrator. Clinical Record Review of Medication Administration Record and physician orders which included the residents of concern. Document Review included facility policy and procedures.			
Y 0102 SS= D	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee.	Y 0102	1) How you will correct the specific find(s) stated in the Statement of Deficiencies. Employee #5 will complete physical on 5/11/2026 and cultural competency on 5/15/2026. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur. Administrator	05/22/2026

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	Inspector Comments: Based on employee record review and interview, the facility failed to ensure initial and annual tuberculosis (TB) screening had been completed for 1 of 6 sampled employees (Employee #5), and an initial physical examination was completed upon hire for 1 of 6 sampled employees (Employee #5). Findings include: TB Test Employee #5 Employee #5 was hired as Activities Personnel on 03/24/2025. Employee #5's employee record lacked documented evidence of a TB test completed by 01/21/2026. On 05/11/2026 at 12:20 PM, the Administrator verbalized Employee #5 had originally worked as a volunteer, and no TB test had been requested of the employee upon date of hire. The facility's plan of correction (POC) submitted 01/22/2026, documented employees will have TB tests completed annually with a date of compliance of 01/21/2026. Physicals Employee #5 Employee #5 was hired as Activities Personnel on 03/24/2025. Employee #5's employee record lacked documented evidence of a physical examination completed by 01/21/2026. On 05/11/2026 at 12:20 PM, the Administrator verbalized Employee #5 had worked as a volunteer prior to hire and had not completed a physical examination upon hiring.		and/or resident service director will oversee hiring process to ensure all required physicals and training are completed in a timely manner. 3)How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Personnel file audits will be conducted to ensure required items are in files. 4)The title of the person(s) responsible for ensuring the plan of correction is implemented. Administrator and/or resident service director. 5) The date the corrective action will be completed. 5/15/2026	

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	The facility's POC submitted 01/22/2026, documented new employees will have physical exams completed prior to starting employment with a date of compliance of 01/21/2026. Employee #5 should have had a physical exam completed by 01/21/2006. Severity: 2 Scope: 1			
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) and First Aid retraining was completed timely for 1 of 6 sampled employees (Employee #2) Findings include: Employee #2 Employee #2 was hired as Resident Service Director on 01/22/2018. Employee #2's record documented most recent retraining of CPR and First Aid expired on 03/14/2026 and lacked documented evidence of retraining completed. On 05/11/2026 at 12:20 PM, the Administrator and the Resident Service Director confirmed Employee #2's CPR and First Aid training had expired on 03/14/2026.	Y 0106	1)How you will correct the specific finding stated in the Statement of Deficiencies. Employee #2 will complete CPR, First Aide AED training. 2) What measures or systematic change will be put into place to ensure the deficient practice does not recur. Yearly training for employee will be monitored using compliance worksheet. 3) How the corrective action will be monitored to ensure the deficient practice will not recure. Resident Service Dire tor will utilize a compliance worksheet to monitor mandated training. 4)The title of 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. 4/30/2026	05/22/2026

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	The facility's plan of correction (POC) submitted 01/22/2026, documented CPR certifications would be monitored using a spreadsheet to keep track of training due dates with a date of compliance of 11/20/2025. Severity: 2 Scope: 1			

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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 6 employees acquired cardiopulmonary resuscitation (CPR) and First Aid training within 30 days of hire (Employee #5) Findings include: Employee #5 Employee #5 was hired as Activities Personnel on 03/24/25. Employee #5's personnel record lacked documented evidence of CPR/First Aid training completed by 01/01/2026. On 05/11/2026 at 12:20 PM, the Administrator confirmed Employee #2 had not completed CPR/First Aid Training. The facility's plan of correction (POC) submitted 01/22/2026, documented employees will complete CPR training within 30 days of hire with a date of compliance of 01/01/2026. Severity: 2 Scope: 1	Y 0450	1)How will you correct the specific finding Statement of Deficiencies. Employee #5 will take CPR class on June 8, 2026. 2) What measures or systematic change will be put into place to ensure the deficient practice does not recur. Employee will be signed up for CPR class upon hire to ensure they attend class within 30 days. 3) How the corrective action will be monitored to ensure the deficient practice does not recur. As part of the hiring process staff will be signed up for CPR class. 4) The title of person(s) responsible for ensuring the plan of correction is implemented. Administrator. 5) The date the corrective action will be completed, 06/08/2026	06/08/2026

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Y 0885 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, interview, record review, and document review the facility failed to ensure expired medications were removed from a medication cart and destroyed on or before the expiration date for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 02/01/2025, with diagnoses including chronic obstructive pulmonary disease, hypertension and insomnia. A Physician's Order dated 10/15/2025, documented Benzonate 200 milligram (mg) capsule, take one capsule by mouth three times daily as needed for cough. On 05/11/2026 at 1:43 PM, during a review of Resident #5's medications and in the presence of the Medication Technician, a bottle containing Benzonate 200 mg	Y 0885	1) How will you correct the specific finding stated in the statement of deficiency. The expired medication that was discovered on the cart was destroyed. 2) What measures or systematic changes will be put into place to ensure the deficient practice doesn't recur. Medication audits will be conducted 3)How the corrective action be monitored to ensure the deficient practice doesn't recur. Medication audits. 4) The title of person responsible for ensuring the plan of correction is implemented. Administrator and/or Resident Service Director. 5)Date action will be corrected. 5/22/2026	05/22/2026

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	capsules was stored in the medication cart, with the resident's active medications. The expiration date printed on the label was 03/13/2026. On 05/11/2026 at 1:47 PM, the Medication Technician confirmed the medication was expired. The Medication Technician verbalized if a medication was expired, the medication was to be removed from the cart and destroyed. Severity: 2 Scope: 1			
Y 0878 SS= D	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 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;	Y 0878	1) How will you correct the specific findings state in the Statement of Deficiencies. Medication Technician will put a "Change of Direction" sticker on medication. 2)What measures or systematic change will be put into place. Medication cart audits will be conducted. 3) How the corrective action will be monitored to ensure the deficient practice does not recur. Resident Service Director will monitor cart audits. 4) The person responsible for ensuring plan of correction is implemented. Administrator 5) The date: 5/22/2026	05/22/2026

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	(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 a change order label sticker was placed on the medication to administer per the physician order for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 02/01/2025, with diagnoses including chronic obstructive pulmonary disease, hypertension and insomnia. A physician order dated 02/26/2026, documented Budesonide 0.5 milligram (mg)/2 milliliters (ml) suspension for nebulization, use one nubule twice daily as needed. Mix with nasal saline irrigate and rinse once to twice daily as directed. On 05/11/2026 at 1:45 PM, the medications for Resident #5, located in the medication			

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	cart, contained Budesonide 0.5mg/2 ml suspension for nebulization, use one nebule 1 to 2 times daily as directed, mix with nasal saline irrigate and rinse 1 to 2 times daily. The May 2026 Medication Administration Record (MAR) for Resident #5, documented Budesonide 0.5 milligram (mg)/2 milliliters (ml) suspension for nebulization, mix with nasal saline twice daily. On 11/17/2025 at 3:02 PM, the Medication Technician verbalized being unable to administer a range order and confirmed the Budesonide needed a change label sticker when the facility received clarification from the physician on how to administer the medication. Severity: 2 Scope:1			
Y 0920 SS= D	NAC 449.2748 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-	Y 0920	1) How will you correct the specific findings stated in the Statement of Deficiencies. Resident #5 will have the medication properly labeled. 2) What measures or systematic changes will be put into place to ensure the deficient practice does not recur. Medication will be labeled when it is received. 3) How the corrective action will be monitored to ensure the deficient practice will not recur. Medication cart audit will be completed by medication technicians and resident service director. 4) The title of the person responsible for ensuring the plan of correction is implemented. Administrator. 5) The date the corrective action be completed. 5/11/2026	05/22/2026

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	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 and physician names for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 02/01/2025, with diagnoses including chronic obstructive pulmonary disease, hypertension and insomnia. A physician order dated 10/15/2025, documented Milk of Magnesia oral suspension 400 milligram (mg)/5 milliliters (ml), take 30 ml by mouth every 24 hours as needed for constipation. On 05/11/2026 at 1:45 PM, the Milk of Magnesia bottle located in the medication cart for Resident #5, lacked a label documenting the resident's name and the name of the physician who ordered the medication. On 05/11/2026 at 1:49 PM, the Medication Technician confirmed the Milk of Magnesia bottle was for Resident #5 and the			

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	physician order was to administer as needed for constipation. The Medication Technician confirmed the medication bottle should have had a label documenting the resident and physician names but it did not. Severity: 2 Scope: 1			
Y 0890 SS= A	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; (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	Y 0890	1) How will you correct the specific finding stated in the Statement of Deficiencies. Resident #5 will have the medication added to his MAR. 2) What measures or systematic changes will be put into place to ensure the specific finding don't recur. MAR audits and staff in-servicing will be completed. 3)How the corrective action be monitored to ensure the deficient practice don't recur. MAR audits will be completed. 4) The person(s) responsible for implementing Plan of Correction. Administrator and/or Resident Service Director. 5) The date the corrective action be completed. 5/22/26	05/22/2026

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	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 ensure a resident's medication administration record (MAR) accurately documented a physician's order for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 02/01/2025, with diagnoses including chronic obstructive pulmonary disease, hypertension and insomnia. A Physician's order dated 10/15/2025, documented Senna 8.6-50 milligram (mg) tablet, take two tablets by mouth every two hours as needed for constipation. Resident #5's medications on-site contained Senna 8.6-50 milligram (mg) tablet, take two tablets by mouth every two hours as needed for constipation. Resident #5's May 2026 MAR lacked Senna 8.6-50 milligram (mg) tablet, take two tablets by mouth every two hours as			

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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
	needed for constipation. On 05/11/2026 at 1:49 PM, the Medication Technician confirmed Resident #5's Senna Plus was not documented on the resident's MAR. Severity: 1 Scope: 1			
Y 1540 SS= E	**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 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	Y 1540	1) How will you correct the specific find(s) stated in the Statement of Deficiencies. Employee #3 #5, #6 will complete Cultural Competency. 2) What measures or systematic changes will be put into place to ensure deficient practice does not recur. Employees will sign up for training within 90 days. 3)How the corrective action be monitored to ensure the deficient practice does not recur. Resident service Director will track training using a compliance worksheet. 4) The title of person responsible for plan of correction. Administrator and/or Resident Service Director 5) The date corrective action completed. 5/22/2026	05/22/2026

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 _____	05/11/2026

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	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 personnel record review and interview, the facility failed to ensure initial cultural competency training was completed within 90 days of hire for 3 of 6 sampled employees (Employees #3, #5, and #6) Findings include: Employee #3 Employee #3 was hired as a Medication Technician/Resident Assistant on 10/02/2025. Employee #3's personnel record lacked documentation of completed cultural competency training. Employee #5 Employee #5 was hired as Activities Personnel on 03/24/2025. Employee #5's personnel record lacked documentation of completed cultural competency training.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Employee #6 Employee #6 was hired as a Resident Assistant on 10/15/2025. Employee #6's personnel record lacked documentation of completed cultural competency training. On 05/11/2026 at 12:20 PM, the Administrator confirmed Employee #3, #5, and #6 lacked completed cultural competency training. The facility's plan of correction (POC) submitted 01/22/2026, documented personnel file check list would be used to ensure training was completed with a date of compliance of 01/21/2026. Severity: 2 Scope: 2			