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 _____	**02/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON VALLEY RESIDENCE, LLC	**705 SOUTH STREET, YERINGTON, NEVADA ,89447**

(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 investigation conducted in your facility on 02/18/2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 57 Residential Facility for Group beds for elderly or disabled persons, and/or persons with Alzheimer's disease, 45 Category II residents and 12 Category II Alzheimer's residents. The census at the time of the survey was 42. Four resident files were reviewed. There was one complaint investigated. Complaint #NV00073292 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: The facility failed to provide adequate staffing to resident ratios at all times. Allegation #2: The facility failed to provide proper grooming procedures for a resident resulting in excessive body odor. Allegation #3: The facility failed to provide proper incontinent care resulting in a resident being left soiled for an extended period of time. Allegation #4: The facility failed to provide proper grooming procedures resulting in poor hygene for a resident. Allegation #5: The facility failed to provide safety to residents located within the memory care unit. The investigation into the allegations included: Observations of staff interactions with residents, including the resident of concern, in common areas and resident rooms. Interviews were conducted with one resident, including the resident of concern, The Wellness Director, the Business Office Manager, and the Administrator. Review of four resident records included Medication Administration Records (MARs), shower schedules, shower refusal documentation, physician assessments, history and physicals, care plans, and progress notes. Document review included the Resident Rights Policy, Abuse policy, and staffing assignments. The findings and conclusions of any	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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.

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 _____	**02/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON VALLEY RESIDENCE, LLC	**705 SOUTH STREET, YERINGTON, NEVADA ,89447**

(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
	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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.			