STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1959	A. BUILDING _____ B. WING _____	10/28/2025

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation and re-grading survey initiated at your facility on 10/14/2025 and finalized on 10/28/2025. 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. Ten resident files and four employee files were reviewed. The facility received a grade of A. Two Complaints (CPTs) were investigated. CPT #12232 could not be substantiated. No regulatory deficiencies could be identified. CPT #NV00074643 could not be substantiated. No regulatory deficiencies could be identified. The investigation into the CPTs			

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	included: Observation of grooming and physical appearance for residents, meal observation, staff-to-resident interactions, and a tour of the facility. Interviews were conducted with residents, a caregiver, a Medication Technician, and the Administrator. Clinical Record Review of ten records, which included the residents of concern. Document Review included personnel record review of four employees and facility policies and procedures related to abuse, feeding assistance, and basic care services.			
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-	Y 0878	1. Resident #2-Medication change label was added to the medication bottle. Resident #1-Contacted physician, awaiting updated medication order allowing the facility to use any brand adult multivitamin. 2. On October 30, 2025, a staff meeting was held with all medication technicians to review medication policies. Reminded of the importance of	11/14/2025

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	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 observation, interview, and record review the facility failed to ensure a medication in use had a change label placed on the medications label when the medication's frequency was changed by a physician's order for 1 of 9 sampled residents (Resident		adding medication change labels to medications that do not match the order/MAR and also spoke about making sure we are administering the correct medications that the physician has ordered. A medication audit checklist will be implemented to ensure that nothing is missed during both monthly audits 3. Wellness team and Med techs will complete a mid-month and end of the month medication audit using the audit checklist. 4. Wellness Director, Assistant Wellness Director, Med techs 5. 11/14/2025	

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	#2) and medications were being administered per the physician orders for 1 of 9 sampled residents (Resident #1) Findings include: Resident #2 Resident #2 was admitted to the facility on 09/15/2025, with diagnoses including Alzheimer's disease. On 10/14/2025 at 11:19 AM, during a review of Resident #2's medications, the following was observed: - a bottle of Quetiapine 25 milligram (mg) tablets, take one tablet at onset of irritation, as needed was documented on the medication's label. - the October 2025 Medication Administration Record (MAR) documented Quetiapine 25 mg tablets, take one tablet at onset of irritation, as needed and take one tablet by mouth at bedtime for Alzheimer's. The physicians order for Resident #2's dated 08/27/2025, documented the following: - Quetiapine 25 mg tablets, take one tablet at onset of irritation, as needed. The physicians order for Resident #2's dated 08/31/2025, documented the following: -Quetiapine 25 mg tablets, take one tablet by mouth at bedtime for Alzheimer's. On 10/14/2025 at 11:21 AM, the Medication Technician #1 confirmed the MAR and the instructions on the medication label for Quetiapine lacked a change label. Resident #1 Resident #1 was admitted to the facility on 05/02/2022, with diagnoses including senile degeneration. On 10/14/2025 at 12:09 PM, during a review of Resident #1's medications, the following was observed: -Therms multivitamin tablet with folic acid, take one tablet daily. - the October 2025 Medication Administration Record (MAR) documented Tab-a-Vit tablet with beta carotene, take			

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	one ablet by mouth daily. The physicians order for Resident #1's dated 07/23/2025, documented the following: -Tab-a-Vit tablet with beta carotene, take one ablet by mouth daily. On 10/14/2025 at 12:12 PM, the Medication Technician #2 confirmed the medication being administered to Resident #1 was not the same as the physician's order and what was documented on the MAR. The Medication Technician #2 verbalized needing to contact the physician to ensure the proper medication was being administered to the resident. 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. All Ensure nutritional supplements have been properly labeled with the resident's name and the prescribing physician's name 2. Typed and printed labels will be prepared and kept readily available for all medication technicians to ensure quick and accurate labeling of OTC medications. A medication audit checklist will be implemented to ensure that nothing is missed during both monthly audits 3. The Wellness Team will work together to complete our months-end medication audit in which the audit check list will be used. 4. Wellness Director, Assistant Wellness Director	11/12/2025

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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 observation, interview, and clinical record review, the facility failed to ensure an over-the-counter (OTC) medication was labeled with the name of the resident for whom the medication was prescribed and the name of the prescribing physician for 1 of 9 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 05/09/2025, with diagnoses including dementia and lung cancer. A physician's order dated 07/21/2025, documented nutrition supplement Ensure Plus vanilla liquid. Drink one bottle by mouth twice a day for nutritional supplementation. On 10/14/2025 at 12:06 PM, during a review of Resident #6's medications, and in the presence of a Medication Technician (Med Tech), a medication container label documented Ensure. The Ensure label lacked Resident #6's name and the name of the prescribing physician. On 10/14/2025 at 12:06 PM, the Med Tech		5. 11/12/2025	

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	explained OTC medications were expected to be labeled with the resident's name, the physician's name, and the expiration date. The Med Tech confirmed Resident #6's Ensures were not labeled with Resident #6's name nor the name of the prescribing physician. Severity: 2 Scope: 1			
Y 0905 SS= D	**NAC 449.2746** **Administration of medication: Restriction concerning medication taken as needed by resident; written records.** 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his need for the medication; (b) The determination is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the amount of medication that may be given, and the frequency with which the medication may be given. 2. A caregiver who administers medication toa resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration;	Y 0905	1. Awaiting new physician order stating PRN indication use and requested that the medication label match the order from the physician 2. On October 30, 2025, a staff meeting was held with all medication technicians to review medication policies, including the proper procedure for accepting and following physician orders. Staff were reminded of the importance of verifying any orders that appear incorrect with the prescribing physician before administering any medication on the medication administration record (MAR). All medication technicians were made aware that orders cannot be accepted or started on the MAR without proper clarification. A medication audit checklist will be implemented to ensure that nothing is missed during both monthly audits All facility PRNs will be assessed to ensure PRN	11/14/2025

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	(b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) 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. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to ensure an as needed (PRN) medication included written instructions indicating a specific symptom for which the medication was to be given for 1 of 9 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 07/03/2025, with diagnoses including atrial fibrillation and stroke. A physician's order dated 09/23/2025, documented Senna Plus (Sennosides-Docusate Sodium) 8.6-50 milligram (mg) tablet. Take two tablets (17.2-100 mg) at bedtime as needed. Hold for loose stool. Resident #8's October 2025 Medication Administration Record (MAR) documented Senna Plus 8.6-50 mg. Take two tablets by mouth at bedtime as needed. Hold for loose stool. On 10/14/2025 at 11:30 AM, during a review of Resident #8's medications, and in the presence of a Medication Technician (Med Tech), a medication container label documented Senna. Take two tablets by mouth at bedtime as needed.		indicators are included in the physician's order 3. The Wellness Team will work together to complete our months-end medication audit in which the audit check list will be used. 4. Wellness Director, Assistant Wellness Director 5. 11/14/2025	

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	On 10/14/2025 at 11:30 AM, the Med Tech confirmed Resident #8's Senna Plus medication label, MAR, and physician's order lacked an indication for use. 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	Y 0890	1. The medication sheet was corrected to match the physicians and reviewed to ensure the Physician's order. Corrected-10/14/2025 2. On October 30, 2025, a staff meeting was held with all medication technicians to review medication policies. Staff were reminded of the critical requirement that the medication label, the MAR, and the order must always match before administering any medication. A medication audit checklist will be implemented to ensure that nothing is missed during both monthly audits. 3. The facility will now utilize its own medication administration record (MAR) sheets, rather than pharmacy-printed sheets, to reduce the risk of errors. The Wellness Team will complete and update the MARs at the end of each month. 4. Wellness Director, Assistant Wellness Director	11/30/2025

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	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 ensure the Medication Administration Record (MAR) was complete and accurate for 1 of 9 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 05/02/2022, with diagnoses including senile degeneration. On 10/14/2025 at 12:12 PM, during medication review, Losartan Potassium 50 milligram (mg), take one tablet by mouth once a day and Senna Plus 8.6-50 mg tablet, take one tablet twice daily as needed for constipation were available to administer to the resident. A physician's order dated 01/13/2025, documented Losartan Potassium 50 mg, take one tablet by mouth once a day.		5. 11/30/2025	

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	A physician's order dated 07/23/2025, documented Senna Plus 8.6-50 mg tablet, take one tablet twice daily as needed for constipation. The October 2025 MAR for Resident #1 documented Losartan Potassium25 mg, take one tablet by mouth once a day and Senna 8.6 mg tablet, take one tablet twice daily as needed for constipation. On 10/14/2025 at 12:15 PM, the Medication Technician confirmed Losartan and Senna were incorrect on the resident's October 2025 MAR and explained all medications were to be transcribed on the MAR to be able to document medication administration to a resident accurately. Severity: 1 Scope: 1			
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:	Y 0885	1. Medication was discontinued on 10/14/2025; the new bottle of medication was added to the medication cart the same day. 2.On October 30, 2025, a staff meeting was held with all medication technicians to review medication policies. Staff were reminded that during medication audits, all extra medications in the carts need to be reviewed to ensure the label matches the MAR and that the med is not expired. A medication audit checklist will be implemented to ensure that nothing is missed during both monthly audits. An audit sign out sheet will be	10/30/2025

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	Based on observation, interview, and clinical record review, the facility failed to ensure an expired medication was removed from a medication cart and destroyed for 1 of 9 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 05/09/2025, with diagnoses including dementia and lung cancer. On 10/14/2025 at 12:06 PM, during a review of Resident #6's medications, and in the presence of a Medication Technician (Med Tech), a medication container documented Vitamin B-12 1000 microgram (mcg). Take one tablet by mouth once daily for vitamin B12 supplementation. The medication had an expiration date of 05/19/2025. On 10/14/2025 at 12:06 PM, the Med Tech confirmed the VitaminB-12 was expired and explained the facility should have destroyed the expired medication and requested a refill. Severity: 2 Scope: 1		created for all involved to sign off when completed. 3. The Wellness Team will work together to complete our months-end medication audit in which the audit check list will be used. Medication Techs will complete the mid month audit using the audit checklist. 4. Wellness Director, Assistant Wellness Director, Medication Techs 5. 10/30/2025	