STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2916	A. BUILDING _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ASSISTED LIVING AT HENDERSON	1050 E LAKE MEAD PARKWAY, HENDERSON, NEVADA ,89015

(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 an annual State Licensure survey and Complaint Investigation completed at your facility on 04/15/26. The facility is licensed for 70 Residential Facility for Group beds for elderly and/or disabled persons and/or persons with mental illness and/or persons with intellectual disabilities and/or persons with Alzheimer's disease, and provides assisted living services, Category II residents. The census at the time of the survey was 48. Fifteen resident files and ten employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Unsubstantiated: 3. Complaint#NV00013209 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Interviews were conducted with the Wellness Director. Record Review of employee files, which included the employee ofconcern.			
Y 0065 SS= E	NAC 449.196 & R043-22 Qualifications of caregivers:	Y 0065	Corrective Action: Employees #2, #5, #7, completed the initial caregiver training hours.	05/09/2026

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	1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156to 449.27706,inclusive, *and sections 2 to 16,inclusive, of this regulation* and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and *(f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility;* and *(g)*Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training *must include, without limitation, at least 2 hours of tier 2 training.* Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 10 sampled employees obtained 1) four hours of initial Caregiver training within the first 60 days of employment and/or 2) eight hours of annual Caregiver training (Employee #2, #5 and #7). Findings include:		E2 completed an additional 15.5 hours total of caregiver and dementia training. Employee files are updated. E5 completed an additional 10 Hrs of dementia/caregiver training. Employee files are updated. E7 has resigned for personal reasons. Their last day on the schedule was 4/12/26. Employee is no longer with our company and will not be on the schedule again. Systemic Changes to Prevent Recurrence: The facility will implement a new-hire training checklist and anniversary training tracker. Staff may not begin work after hire until required onboarding training is verified. The learning coordinator/Assistant Executive Director will issue due-date notices to employees when trainings are due. If trainings are not completed within 7 days of the assignment date, the employee will be taken off of the work schedule. Employees will print certificates immediately upon completion of trainings. Personal files will be updated with proof of completion. Monitoring Plan (who, how often, duration): The Assistant Executive Director, Health and Wellness Director and/or assigned designee will audit the training log weekly for 4 weeks and monthly thereafter for 6 months Responsible Person/ Title: The Assistant Executive Director, Health and Wellness Director and/or assigned designee Date of Correction: 5/9/2026	

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	Employee #2 (E2) E2 was hired on 03/20/25 as a Medication Technician. E2 received a total of 2 hours forty-five minutes of Caregiver training between 03/21/25 and 03/23/25. E2's file lacked documented evidence E2 received an additional five hours 15 minutes of annual Caregiver training. Employee #5 (E5) E5 was hired on 09/01/24 as a Medication Technician. E5 received a total of two hours forty-five minutes of annual Caregiver training between 06/12/25 and 06/13/25. E5's file lacked documented evidence E5 received an additional five hours 15 minutes of annual Caregiver training. Employee #7 (E7) E7 was hired on 09/01/24 as a Caregiver. E7 received a total of one hour fifteen minutes annual Caregiver training 04/30/25. E7's file lacked documented evidence E7 received an additional six hours 45 minutes of annual Caregiver training. On 04/15/26 at 1:00 PM, the Administrator was provided with the opportunity to submit the missing documentation within 72 hours and the documentation was not received. Severity: 2 Scope: 2			
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 record review and interview, the facility failed to ensure 4 of 10 employees received 1) an initial 2-step tuberculous (TB) skin test and/or 2) a physical examination upon hire. (Employee #2, #3, #4, and #9)	Y 0102	Corrective Action: E2 was recorded to have received a 1-step TB skin test on 3/19/25, which upon further review was in-fact a T-spot TB test with a negative result dated the same 3/19/25. E3 was recorded to have received a 1-step TB skin test on 7/7/25, which upon further review was in-fact a T-spot TB test with a negative result dated the same 7/7/25. E4 was recorded to have received a 1-step TB skin test on 9/26/25, which upon further review was in-fact a T-spot TB	04/24/2026

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	Findings include: Employee #2 (E2) E2 was hired on 03/20/25 as a Medication Technician. E2's file documented a negative 1-step TB skin test completed on 03/19/25. There was no documented evidence in E2's file of a second step TB test. Employee #3 (E3) E3 was hired on 07/09/25 as a Caregiver. E3's file documented a negative 1-step TB skin test completed on 07/07/25. There was no documented evidence in E3's file of a second step TB test. Employee #4 (E4) E4 was hired on 09/24/25 as a Caregiver. E4's file documented a negative 1-step TB skin test completed on 09/26/25. There was no documented evidence in E4's file of a second step TB test. Employee #9 (E9) E9 was hired on 01/10/26 as the Executive Director. E9's lacked documented evidence of an initial two-step TB test and a physical examination upon hire. On 04/15/26 in the afternoon, the Executive Director acknowledged there was no documented evidence of a completed initial 2-Step TB skin test for E2, E3, E4, and E9 and no physical examination for E9. Severity: 2 Scope: 2		test with a negative result dated the same 9/26/25. E9 received a QuantiFERON TB test and a Physical Examination on 4/24/26. TB resulted negative. Personnel file was updated. Systemic Changes to Prevent Recurrence: The facility added TB due dates to the annual compliance matrix and implemented reminder checkpoints before the due month and at the due date. All new employees will receive the QuantiFERON TB test to simplify the process and ensure testing is completed. All employees will be schedules to receive their Physical Exam at the same time. No employee will be allowed to start their first day of work until their TB tests and Pre-hire Physical exam are complete and results are acceptable. Monitoring Plan: The Assistant Executive Director, Health and wellness director, and/or designee will ensure that all new hires receive the QuantiFERON TB test and Physical Exam and review the TB tracking log monthly for 6 months Responsible person/Title: Assistant Executive Director, Health and wellness director, and/ or assigned designee Date of correction: 4/24/2026	
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are	Y 0172	Corrective Action: Water Temperatures- After the state surveyors left, we immediately scheduled a plumber to come in. He came in and provided a quote which we immediately moved forward with. The new water hot and cold mixing valve was installed on 4/17. After installation, we began adjusting the	04/18/2026

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	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. Inspector Comments: Based on observation and interview, the facility failed to ensure		valve and testing temperatures in several apartments. The Plumber was unable to provide the time needed before the end of the day on 4/17 to leave the valve set perfectly. The Assistant Executive Director returned the following morning on 4/18 and began testing the temperatures across the whole facility, and adjusting the valve accordingly. The valve was adjusted correctly to provide consistent temperatures across the whole Assisted Living Facility. Faucets in apartments 103, 109, 114, 118, 202, 209, 215, 225, and the second floor hallway Bathroom, in addition to various other apartments, bathrooms, and laundry rooms were tested and the valve adjusted until all were consistent and within the acceptable range of 100-110 degrees Fahrenheit. Photos of the newly installed mixing valve, testing, and corrected temperatures were provided on 4/18 via email to the team of surveyors. Cleanliness- The detergent residue in both the Memory Care and Assisted Living second floor laundry rooms was cleaned up and disinfected to ensure cleanliness by staff members. The upstairs Bathroom was all cleaned thoroughly and disinfected. The fecal matter and dirty water was removed and flushed. The mentioned crack in the wall is simply a crack in the wall panel that is placed around the toilet. There is no apparent damage to the wall or structure of the room itself. Odors- Air purifying spray was purchased and used. The stagnant contents of the toilet were removed and thus the odor was thus removed as well. Cleaning of the entire bathroom was completed and no apparent odors reside. Systematic Changes to ensure compliance: Water Temperatures- The new hot and cold mixing valve and thermostat was installed, thus adding the temperature regulating system to the water path to the apartments. This system can be easily adjusted and	

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	the premises were clean and free of foul odors, and that water temperatures were within the acceptable range. Findings include: On 04/15/26 in the morning, the water temperatures were checked in resident rooms on both floors and on different sides of the building, and in a hallway bathroom. The following temperatures were obtained: At 9:20 AM, the water from the bathroom faucet in Room 202 measured 116.1 degrees Fahrenheit (F). At 10:07 AM, the water from the faucet in the second floor hallway bathroom measured 116.8 degrees F. At 10:15 AM, the water from the bathroom faucet in Room 225 measured 116.4 degrees F. At 10:25 AM, the water from the bathroom faucet in Room 118 measured 117.5 degrees F. At 10:17 AM, the water from the bathroom faucet in Room 215 measured 114.1 degrees F. At 10:30 AM, the water from the bathroom faucet in Room 103 measured 117.0 degrees F. On 04/15/26 in the morning, Employee #9 (E9) acknowledged the elevated water temperatures, and made an adjustment to the water heater with the assistance of the corporate maintenance person via real-time video chat. On 04/15/26 in the afternoon, the water temperatures were checked again by surveyors, and the results were still above the acceptable range. Water temperatures after the adjustment were as follows: At 12:43 PM, the water from the bathroom faucet in Room 103 measured 116.6 degrees F.		monitored to ensure the temperature coming out of the faucets across the whole facility is maintained within the acceptable range. On June 1st we will start our newly hired maintenance Director who will directly oversee and maintain the regulation of the facilities water temperatures. Cleanliness- The resident laundry rooms will be added to the weekly cleaning assignments of the Housekeeper, ensuring routine checkins and cleaning/maintaining. We have plans and arrangements to fully remodel the residential laundry rooms, including new wall paint, flooring, washer, dryer, and soap distribution mechanism. The first step is the scheduled flooring to come in and be installed the week of May 25th. We will immediately discontinue the current method of soap distribution and implement a new method to ensure the issue is completely resolved. In the second floor hallway bathroom, after further inspection, The toilet was found to not be in operating order after its supposed repair from our terminated Maintenance Director. The plumbing will be repaired or the toilet replaced after its new floor installment to ensure its lasting functionality and availability. Odors- All public Bathrooms will be checked and cleaned daily, 5 days a week, by the facilities housekeeper. If after cleaning, and odors reside in the bathrooms, air purifier will be sprayed. Permanent air fresheners mounted to the walls will continue to be monitored for usage, refill, and overall functionality by the housekeeper and the contracted provider. Monitoring plan: Water Temperatures- The Assistant Executive Director, Maintenance Director, and/or other designee will check and log facility hot water temperatures weekly.	

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	At 12:45 PM, the water from the bathroom faucet in Room 109 measured 115.9 degrees F. At 12:50 PM, the water from the bathroom faucet in Room 114 measured 112.3 degrees F. At 12:53 PM, the water from the bathroom faucet in Room 215 measured 114.0 degrees F. At 1:00 PM, the water from the bathroom faucet in Room 209 measured 115.3 degrees F. On 04/15/26 in the afternoon, E9 acknowledged the water heater adjustment had not been effective in bringing down the water temperatures. On 04/15/26 at 9:42 AM, a thick accumulation of detergent residue was observed on the floor underneath and next to the washing machine in the second floor laundry room. A Housekeeper explained the laundry detergent dripped from the hose placed in the source bucket next to the washing machine, but could not verify for certain that this was the cause of the detergent build-up. E9 acknowledged the residue was an issue. On 04/15/26 at 9:57 AM, a housekeeper unlocked a hallway bathroom on the second floor of the south wing of the Assisted Living side of the facility to enable the surveyor to enter. The toilet was non-functioning, and the toilet bowl contained a mass of dried fecal matter with a layer of translucent substance covering it. The bathroom had a foul odor. The housekeeper reported that about a month ago, the water and the toilet had been so hot that a humid environment had been created in the bathroom. E9 explained the water had been turned off to the toilet because the water source hose had been spraying, and that currently the toilet was not leaking. The wall behind the toilet was cracked. The Assistant to the Executive Director indicated the toilet had not been fixed because the facility maintenance person's last day of work had		Adjustments to the mixing valve can and will be made if needed. Cleanliness- Housekeeping and Care staff will review daily the facility's laundry rooms and public bathrooms. They will provide day-to-day cleaning and maintenance. Any major repairs or issues will be reported immediately to the Assistant Executive Director, Health and Wellness Director, and/or Maintenance Director. Odors- Housekeeping and Care staff will review daily the facility's public bathrooms. They will provide day-to-day cleaning and maintenance. Any major repairs or issues will be reported immediately to the Assistant Executive Director, Health and Wellness Director, and/or Maintenance Director. Person/Title responsible: Water Temperatures- Assistant Executive Director, Maintenance Director, and/or other designee. Cleanliness- Assistant Executive Director, Health and Wellness Director, Maintenance Director, and/or other designee. Odors- Assistant Executive Director, Health and Wellness Director, Maintenance Director, and/or other designee. Date of completion: 4/18/26	

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	been 03/20/26. On 04/15/26 at 10:53 AM, many black, white, and brown blotches of crystallized laundry detergent or another substance were observed on the floor of the laundry room in the Memory Care Unit next to the washing machine. In addition, laundry detergent had dripped down the side of the washing machine and had dried into white and brown lines. E9 acknowledged the unsightly mess and agreed it should be cleaned up. Severity: 2 Scope: 3			
Y 0255 SS= E	NAC 449.217 6. A residential facility with **more than 10 residents** must: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Division and the state and local fire safety authorities. Inspector Comments: Based on observation on 04/15/2026, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. There was no detectable level of chlorine sanitizer dispensed during the final rinse cycle at the low temperature dish	Y 0255	Corrective Action: Critical Violation- The kitchen team began washing, rinsing, sanitizing, and drying all dishware and cookware in the 3-compartment sink after the sanitizer was not reading during the final rinse cycle of the dish machine. Ecolab was called on 4/15 to correct the issue with the sanitizer line on the dish machine. They arrived at the facility on 4/16 and corrected the sanitizer issue. Major Violation- The kitchen team cleaned washed, rinsed, and sanitized cook line equipment, the memory care microwave, the memory care refrigerator, and the activity refrigerator/freezer on 4/15 and 4/16. Equipment and Maintenance Violation- The kitchen team cleaned the surrounding area of the ceiling vents and removed all vents and washed, rinse, and sanitized them on 4/15 and 4/16. Systemic Changes to Prevent Recurrence & Monitoring plan: Critical Violation- Ecolab will service their chemical equipment quarterly. A low temperature dish machine log, which includes a wash and rinse temperature and a final rinse ppm reading, will be	04/30/2026

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	machine. 2. Major Violations: a. The following non-food contact surfaces were soiled with food and debris: the sides of the cook's line equipment, the interior of the memory care microwave, the interior of the memory care refrigerator, and the interior of the activity refrigerator/freezer. 3. Equipment and Maintenance Violations: a. There was dust build-up around the ceiling air vents throughout the kitchen. Severity: 2 Scope: 2		implemented. The log will be completed 3 times per day indefinitely. Major Violation- The deficient areas will be added to the existing kitchen cleaning log. Weekly cleaning will include the cook equipment, the memory care refrigerator, and the activity refrigerator/freezer. Daily cleaning will include the memory care microwave. Equipment and Maintenance Violation- The ceiling vents and surrounding areas will be added to the existing monthly kitchen cleaning log. Responsible Person/ Title: Assistant Executive Director, Dietary services Manager and/or assigned designee Completion Date: 4/30/2026	
Y 0690 SS= D	NAC 449.2712 Residents requiring use of oxygen. 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his need for oxygen; and (2) Administering the oxygen to himself with assistance.	Y 0690	Corrective Action: The resident receiving oxygen was immediately reviewed by nursing/ clinical leadership on resident capability and understanding of safe handling / storage of oxygen. Resident was reviewed and found unable to self administer and manage medications and oxygen. The facility created a new Care plan for the resident, including medication management and oxygen management services. Systemic Changes to Prevent Recurrence: Unneeded oxygen cylinders were collected. Oxygen order was reviewed and updated. New oxygen will be securely stored in a designated oxygen safe storage space with appropriate signage. We will perform daily reviews and safety checks for residents with oxygen and oxygen tanks to ensure safe handling/storage is maintained. Monitoring Plan (who, how often, duration): The Health and Wellness Director and/or assigned Medication Technician/care staff	04/30/2026

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	2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. 3. The administrator of a residential facility shall ensure that the caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen.		will review and check on residents with oxygen daily. Responsible Person/ Title: The Health and Wellness Director and/or assigned Medication Technician/care staff Completion date: 4/30/2026	

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	2916	A. BUILDING _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ASSISTED LIVING AT HENDERSON	1050 E LAKE MEAD PARKWAY, HENDERSON, NEVADA ,89015

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	Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 04/15/26 at 9:02 AM, three unsecured oxygen tanks were observed on a patio in a resident's fenced back yard. On 04/15/26 at 10:48 AM, the Assistant to the Executive Director acknowledged the oxygen tanks should have been secured. Severity: 2 Scope: 1			
Y 0930 SS= D	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone	Y 0930	Corrective action: The residents sampled were reviewed for admission TB compliance and missing documentation will be obtained or follow up testing arranged per regulation. Updated TB status will be updated in resident records. Unfortunately, R10 passed away and no longer resides at the facility. Systemic Changes to Prevent Recurrence: The facility implemented a resident admission checklist requiring TB compliance, admission orders, H&P , ADL assessment, physician documentation, and file completeness before the admission files are considered closed. A separate chart-audit tool was implemented by the admission/sales director to ensure all paperwork is collected before move in. Monitoring Plan: Assistant Executive Director, Community Admissions/Sales Director, Health and Wellness Director and/ or assigned designee will continuously verify all new admissions have completes files with all required information. The week after new admissions are admitted, their files will be reviewed again to ensure complete documentation has been made to meet requirements. Random resident records will be pulled and audited monthly for 6 months. Responsible person/title:	05/17/2026

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	number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any		Assistant Executive Director, Community sales Director, Health and Wellness Director, and/ or assigned designee Anticipated date of completion: 05/17/2026	

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	assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies			

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	while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure an initial two-step tuberculosis (TB) test was completed for 1 of 15 sampled residents (Resident #10). Findings include: Resident #10 (R10) R10 was admitted on 11/10/23, with diagnoses including diabetes. R10's file revealed a one-step TB test was completed on 09/10/24 and another one-step TB test administered on 10/07/25 that was not read. R10's file lacked documented evidence of a two-step TB test. On 04/15/26 in the afternoon, the Wellness Director acknowledged the incomplete TB tests and was unable to provide a two-step TB test. Severity: 2 Scope: 1			

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Y 1035 SS= F	NAC 449.2768 **Residential facility which provides care to persons with Alzheimer's disease: Alzheimer's/dementia Training:** 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the	Y 1035	Corrective Action: Employees #2, #4, #5, #6, #7, #8, #9, #10, were immediately reviewed and scheduled for required Alzheimer's training to fulfill their first 40 hours, and Alzheimer's training for their first 90 days. E2 was provided with 15.5 hours of Alzheimer's training. E4 was provided with 8.25 hours of Alzheimer's training. E5 was provided with 10 hours of Alzheimer's training. E6 was provided with 4 hours of Alzheimer's training. E7 voluntarily resigned from our company. Their last day on the schedule was 4/12/26. E8 was provided with 10.5 hours of Alzheimer's training. E9 was provided with 8.75 hours of Alzheimer's training. E10 was provided with 11.5 hours of Alzheimer's training. Systemic Changes to Prevent Recurrence: Alzheimer's training was added to the onboarding checklist and annual compliance matrix. All Employees will now be required to print training certificates immediately following their trainings if done online. No employee may be on the work schedule until completion of the Alzheimer's training. Upon completion, employee files will be updated. Monitoring Plan: Assistant Executive Director, Health and Wellness Director and/ or assigned designee will audit the Alzheimer's training roster weekly for 4 weeks and monthly for 6 months. Responsible person/title: Assistant Executive Director, Health and Wellness Director and/ or assigned designee Completion date: 5/13/2026	05/13/2026

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	facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on record review and interview, the facility failed to ensure 8 of 10 sampled employees obtained 1) two hours of Alzheimer's training within the first 40 hours of employment, 2) an additional eight hours of Alzheimer's training within the first 90 days of employment, or 3) three hours of Alzheimer's training annually (Employee #2, #4, #5, #6, #7, #8, #9, and #10). Findings include: Employee #2 (E2) E2 was hired on 03/20/25 as a Caregiver. E2's file lacked documented evidence E2 received two hours of Alzheimer's training within the first 40 hours of employment and an additional eight hours of Alzheimer's training within the first 90 days of employment. Employee #4 (E4) E4 was hired on 09/24/25 as a Caregiver. E4's file lacked documented evidence E4 received two hours of Alzheimer's training within the first 40 hours of employment and an additional eight hours of Alzheimer's training within the first 90 days of employment.			

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	Employee #5 (E5) E5 was hired on 09/01/24 as a Medication Technician. E5 received a total of one hour fifteen minutes of Alzheimer's training between 01/30/26 and 04/07/26. E5's file lacked documented evidence E5 received an additional one hour 45 minutes of Alzheimer's training annually. Employee #6 (E6) E6 was hired on 09/01/24 as a Caregiver. E6 received a total of one hour fifteen minutes of Alzheimer's training between 01/30/26 and 04/07/26. E6's file lacked documented evidence E6 received an additional one hour 45 minutes of Alzheimer's training annually. Employee #7 (E7) E7 was hired on 09/01/24 as a Caregiver. E7 received a total of one hour fifteen minutes of Alzheimer's training between 01/30/26 and 04/07/26. E7's file lacked documented evidence E7 received an additional one hour 45 minutes of Alzheimer's training annually. Employee #8 (E8) E8 was hired on 08/09/24 as a Health and Wellness Director. E8 received a total of one hour fifteen minutes of Alzheimer's training between 01/30/26 and 04/07/26. E8's file lacked documented evidence E8 received an additional one hour 45 minutes of Alzheimer's training annually. Employee #9 (E9) E9 was hired on 01/10/26 as the Executive Director. E9 received a total of one hour fifteen minutes of Alzheimer's training between 01/30/26 and 04/07/26. E9's file lacked documented evidence E9 received an additional 45 minutes of Alzheimer's training within the first 40 hours of employment and an additional eight hours of Alzheimer’s training within the first 90 days of employment.			

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	Employee #10 (E10) E10 was hired on 08/01/25 as a Medication Technician. E10's file lacked documented evidence E10 received two hours of Alzheimer's training within the first 40 hours of employment and an additional eight hours of Alzheimer's training within the first 90 days of employment. On 04/15/26 at 1:00 PM, the Administrator was provided with the opportunity to submit the missing documentation within 72 hours and the documentation was not received. Severity: 2 Scope: 3			
Y 1840 SS= E	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the agency failed to	Y 1840	Corrective Action: Employees #4, #5, and #6, were immediately reviewed, scheduled, and have completed Infection Control training.Employee files will be updated to reflect current trainings. E7 voluntarily resigned, and their last day on the schedule was 4/12/26. They will not be on the Schedule any longer. Systemic Changes to Prevent Recurrence: Infection Control training was added to the onboarding checklist and annual compliance matrix. Employees will complete infection control training before they are on the work schedule. Employees will be required to print certificates immediately following the conclusion of the course. Employee files will be updated accordingly and current. No employee may provide resident care until completion of the Infection Control training. Monitoring Plan: The administrator, Health and Wellness Director, or designee will audit the Infection Control training roster to ensure all employees are current with training. Any employees needing updated training will be enrolled. New hired employees will not start working with residents until training is complete during the onboarding process. The Assistant Executive Director, Health and Wellness	05/11/2026

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	ensure infection control training, for unlicensed caregivers, was completed for 4 of 10 sampled employees (Employee #4, #5, #6, and #7). Findings include: Employee #4 (E4) E4 was hired on 09/24/25 as a Caregiver. E4's file lacked documented evidence unlicensed caregiver infection control training was completed through a nationally recognized organization. Employee #5 (E5) E5 was hired on 09/01/24 as a Medication Technician. E5's file lacked documented evidence unlicensed caregiver infection control training was completed through a nationally recognized organization. Employee #6 (E6) E6 was hired on 09/01/24 as a Caregiver. E6's file lacked documented evidence unlicensed caregiver infection control training was completed through a nationally recognized organization. Employee #7 (E7) E7 was hired on 09/01/24 as a Caregiver. E7's file lacked documented evidence unlicensed caregiver infection control training was completed through a nationally recognized organization. On 04/15/26 at 1:00 PM, the Administrator was provided with the opportunity to submit the missing documentation within 72 hours, and the documentation was not received. Severity: 2 Scope: 2		Director, or designee will oversee this is organized and completed as stated. Infection control trainings will be reviewed the weekly for 4 weeks and monthly for 6 months. Responsible person/title: Assistant Executive Director, Health and Wellness Director and/ or assigned designee Anticipated Completion date: 5/11/2026	