STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2973	A. BUILDING _____ B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR CARE	5408 TOPAZ STREET, LAS VEGAS, NEVADA ,89120

(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 the State Licensure Annual Grading survey conducted at your facility on 01/22/25, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident records and four employee records were reviewed. The facility received a grade of C. The findings and conclusions of any 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. The following regulatory deficiencies were identified:	0000		
0074 SS= F	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent	0074	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation, Employee #4 has documentation of Elder Abuse from Nevada Care Connection.Employee #1 and Employee #3 has elder abuse training from Nevada Care Connection on July 3, 2024 but it was not on the employees files. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator of Joyful Senior Care will maintain the personnel records for each employee and audit and update these files constantly so that all requirements will be met and carried on at all times. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will maintain employees records and audit and update files constantly so that requirements will be met at all times. 4. The title of the person responsible for	01/27/2025

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	the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for		ensuring the plan of correction is implemented. The administrator is responsible. 5. The date of corrective action will be completed. The corrective action wa completed on January 27, 2025. 6. You must attach all supporting into the system. ATTACHMENT #1 7. How you will identify and correct other areas having potential to be affected by the same practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	

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	groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and record review, the facility failed to ensure annual elder abuse training was completed for 3 of 4 employees (Employee #1, #3 and #4). Findings include: Employee #1 (E1) E1 was hired on 04/20/00 as a Caregiver. E1's employee file contained evidence of elder abuse training received on 03/01/23. E1's file lacked documented evidence of elder abuse training in 2024 or 2025. Employee #3 (E3) E3 was hired on 06/22/09 as a Caregiver. E3's employee file contained evidence of elder abuse training received on 03/01/23. E3's file lacked documented evidence of elder abuse training in 2024 or 2025. Employee #4 (E4) E4 was hired on 09/14/98 as an Administrator. E4's employee file contained evidence of elder abuse training received on 03/01/23. E4's file lacked documented evidence of elder abuse training in 2024 or 2025. On 01/22/25 in the afternoon, the Administrator acknowledged E1, E3 and E4			

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	did not complete annual Elder Abuse training. Severity: 2 Scope: 3			
0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 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 record review and interview, the facility failed to ensure 1 of 4 employees received in person cardiopulmonary resuscitation (CPR) training. (Employee #4) Findings include: Employee #4 (E4) E4 was hired on 09/14/98 as an Administrator. E4's file revealed CPR training was completed online on 02/05/24. E4's record lacked documented evidence of the CPR in person component. On 01/22/25 in the afternoon, the Administrator confirmed the online CPR with no in person component for E4 and acknowledged the in person component was required to be in compliance. Severity: 2 Scope: 1	0106	1. How you will correct the specific findings stated in the Statement of Deficiency? In order to become compliant with regulations, CPR was performed by Employee #4 in person at CPR Connections. Document will be maintained in the Employee #4 file and will be available at anytime. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator of Joyful Senior Care will maintain the personnel records and audit and update files constantly so that all requirements will be met and carried on at all times 3. How the corrective action will be monitored to ensure the deficient practice will nor recur? The administrator of the facility will maintain employees file and audit and update it constantly so that requirements are met and carried on in timely fashion. 4. The title of person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective action will be completed. The corrective action is completed on January 31, 2025. 6. You must attach all supporting documents into the system. ATTACHMENT 2 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	01/31/2025

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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure water temperatures were within the acceptable range of 100 degrees Fahrenheit (F) to 110 degrees Fahrenheit (F) for 2 of 2 resident bathrooms and failed to ensure portable space heaters automatically shut off when tipped over. Findings include: On 01/22/25 in the morning, the water temperature in the resident bathroom near bedroom #4 registered 160 degrees Fahrenheit (F). The water temperature in the resident bathroom near bedroom #5 registered 116.5 degrees Fahrenheit (F). On 01/22/25 in the morning, portable space heaters located in bedroom #4 and bedroom #5 did not automatically turn off when tipped over. On 01/22/25, in the morning, the Administrator acknowledged the water temperature was hotter than the acceptable range of 100 degrees Fahrenheit (F) to 110 degrees Fahrenheit (F) and confirmed the two space heaters did not automatically turn off when tipped over. Severity: 2 Scope: 3	0174	1. How you will correct specific findings stated in the Statement of Deficiencies? In order to become compliant with regulation, on the day of the survey the maintenance person in the facility adjusted the temperature of the water heater to 103 degrees Fahrenheit. All portable space heaters in bedroom #4 and bedroom #5 were removed. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator of the facility will ensure that water heater temperature remains 100 to 110 degrees at all time. The inspection will be done each day to ensure the facility will remains in compliance with the regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will ensure water heater temperature remains the acceptable temperature at all time. Inspection will be done each day to ensure the facility will remain in compliance with the regulation. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date of corrective action will be completed. The corrective action is completed on January 22, 2025. 6. You must attach all supporting documents into the system. ATTACHMENT 3 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adquately addresses other residents.	01/27/2025

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 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 the premises were clean and well maintained. Findings include: The following observations were made in the backyard on 01/22/25 in the morning: - One shower chair. - Three pillows. - One walker. - Two clocks. - One twin bedframe. - One wheelchair. - One large BBQ which was covered in soot and grease. - A stump of a shrub protruding from the ground. - A screen missing on the window next to the back exit door. - A screen missing on bathroom window near the backyard exit gate. - A screen missing on the bedroom window near the backyard exit gate. On 01/22/25 in the morning, the Administrator acknowledged the backyard was not clean and well maintained. The following observations were made on 01/22/25 in the afternoon: - The exterior of the kitchen cabinets had odorous substances on them near the kitchen trash can. - The rice cooker had grease covering it. - The exterior of the oven hood had grease and debris covering it. - The toaster had grease and debris covering it. On 01/22/25 in the afternoon, the Administrator acknowledged the kitchen needed to be wiped down and cleaned. Severity: 2 Scope: 3	0178	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to be compliant with regulation regarding health and sanitation, the administrator of the facility disposed everything in backyard including the barbecue, walker and commode. Stump in the backyard was taken out and new window screen was installed. Kitchen cabinets, walls, oven hood and appliances in the kitchen such as rice cooker, toaster were cleaned. 2. What measures or systematic changes will be put into place to ensure the deficient practice does not recur? The administrator takes responsibility that the facility remains clean and free from grease and offensive odor. The inspection will be done each day to ensure faulty remains in compliance with the regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator is responsible that the facility is clean and free from offensive odor. Inspection is done each day so that facility is in compliance with the regulation. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective will be completed. 6. You must attach all supporting documents into the system. ATTACHMENT 4 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	02/03/2025

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0356 SS= D	Bathrooms and Toilet Facilities - NAC 449.222 Bathrooms and toilet facilities; toilet articles. (NRS 449.0302) 6. Bathroom doors that are equipped with locks must open with a single motion from the inside without the use of a key. If a key is required to open a lock from outside the bathroom, the key must be readily available at all times. Inspector Comments: Based on observation and interview the facility failed to ensure a resident's bathroom door was equipped with a single motion lock. Findings include: On 01/22/25 in the morning, it was observed that the resident bathroom door near bedroom #5 had a lock which required more than one motion to unlock the door leading to the interior of the facility from the bathroom. On 01/22/25 in the morning, the Administrator acknowledged the double motion lock on the door and acknowledged they should be single motion. Severity: 2 Scope: 1	0356	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation, a single motion lock was installed near bedroom #5 bathroom. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator of Joyful Senior will ensure that single motion lock is always operable and facility remains in compliance with regulation at all times. 3. How the corrective action will be monitored to ensure the deficient practice does not recur? The administrator will ensure that single motion lock is operable and checks it constantly so that facility remains in compliance with regulation. 4. The title of the person responsible for ensuring the plan of correction. The administrator is responsible. 5. The date the corrective action will be completed. The corrective action was completed on January 26, 2025. 6. You must attach all supporting documents into the system. ATTACHMENT 5 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	01/26/2025

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0515 SS= E	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to develop a person-centered service plan for 4 of 10 residents (Resident #1, #3, #9, and #10). Findings include: Resident #1 (R1) R1 was admitted to the facility on 09/01/24, with diagnoses including Alzheimer's and kidney disease. R1's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on 03/16/24, with a diagnosis of dementia. R3's file lacked a person-centered service plan. Resident #9 (R9) R9 was admitted to the facility on 11/27/24, with diagnoses including dementia and kidney failure. R9's file lacked a person-centered service plan. Resident #10 (R10) R10 was admitted to the facility on 08/15/24, with diagnoses including chronic kidney disease and hypertension. R10's file lacked a person-centered service plan. On 01/22/25 in the morning, the Administrator confirmed R1, R3, R9, and R10's files did not have person-centered service plans. Severity: 2 Scope: 2	0515	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with regulation, Resident#1, Resident #3, Resident #9 and Resident #10 have documentation of person centered plan and resident's plan of care. All documents will be maintained in the resident's file and will be available at anytime. 2. What measures or systematic changes will be put into place to ensure the deficient practice does not recur? The administrator will maintain the resident's records for each resident and audit and update these files constantly so that all requirement will be met and carried on at all times. 3. How the corrective action will be monitored to ensure the deficient practice will nor recur? the administrator will maintain the resident's file for each resident and audit and update it constantly so that facility is in compliance with the regulation. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective action will be completed. The corrective action was completed on January 23, 2025. 6. You must attach all supporting documents into the system. ATTACHMENT 6 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	01/23/2025

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on interview and record review, the facility failed to obtain a medical exemption to maintain one resident who was bedfast and one resident who received wound care (Resident #7 and #10). Findings include: Resident #7 (R7) R7 was admitted to the facility on 06/15/20 with diagnoses including Alzheimer's and major depressive disorder. On 01/22/25 in the morning, R7 was unable to demonstrate the ability to turn from side to side in bed without assistance. On 01/22/25 in the morning, the Administrator confirmed R7 was unable to turn from side to side in bed without assistance. R7's file lacked documented evidence of an approved bedfast medical exemption from the Bureau. On 01/22/25 in the afternoon, the Administrator acknowledged R7 did not currently have an approved bedfast medical exemption on file. Resident #10 (R10) R10 was admitted to the facility on 08/15/24 with diagnoses including kidney disease and hypertension. A Physician's Order dated 01/10/25 documented R10 was to receive wound care twice weekly from a hospice agency's Registered Nurse on their right heel for an unstageable wound. A Physician's Order dated 01/20/25 documented R10 was to receive routine wound care from a hospice agency's Registered Nurse on their sacrum for a stage 3 pressure ulcer. R10's file lacked documented evidence of an approved medical exemption for receiving wound care from the Bureau. On 01/22/25 in the afternoon, the Administrator acknowledged R10 did not currently have an approved medical exemption on file for having wounds. Severity: 2 Scope: 1	0620	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation, a bedfast medical exemption of Resident #7 was submitted to the bureau.Resident #10 expired on January 30, 2025. All documents will be maintained in the residents's file and will be available at anytime to the bureau. 2. What measures or systematic change will be put into place to ensure the deficient practice will not recur? The administrator will maintain residents records in the residents file and be available at anytime so that facility will be in compliance with regulation. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will maintain residents records in residents file and audit and update the files constantly so that all requirements will be met and carried on at all times. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective action will be completed The corrective action was completed on January 31, 2025. 6. You must attach all supporting documents into the system. ATTCHMENT 7 7. How you will identify and correct other areas having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	01/31/2025

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JOYFUL SENIOR CARE	5408 TOPAZ STREET, LAS VEGAS, NEVADA ,89120

(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
1240 SS= E	Patient's Rights - Patient to be informed - NRS 449A.118 Patient to be informed of rights upon admission to facility; required disclosures and notices. [Effective January 1, 2020.] 1. Every medical facility and facility for the dependent shall inform each patient or the patient's legal representative, upon the admission of the patient to the facility, of the patient's rights as listed in NRS 449A.100 and 449A.106 to 449A.115, inclusive. 2. In addition to the requirements of subsection 1, if a person with a disability is a patient at a facility, as that term is defined in NRS 449A.218, the facility shall inform the patient of his or her rights pursuant to NRS 449A.200 to 449A.263, inclusive. 3. In addition to the requirements of subsections 1 and 2, every hospital shall, upon the admission of a patient to the hospital, provide to the patient or the patient's legal representative: (a) Notice of the right of the patient to: (1) Designate a caregiver pursuant to NRS 449A.300 to 449A.330, inclusive; and (2) Express complaints and grievances as described in paragraphs (b) to (f), inclusive; (b) The name and contact information for persons to whom such complaints and grievances may be expressed, including, without limitation, a patient representative or hospital social worker; (c) Instructions for filing a complaint with the Division; (d) The name and contact information of any entity responsible for accrediting the hospital; (e) A written disclosure approved by the Director of the Department of Health and Human Services, which written disclosure must set forth: (1) Notice of the existence of the Bureau for Hospital Patients created pursuant to NRS 232.462; (2) The address and telephone number of the Bureau; and (3) An explanation of the services provided by the Bureau, including, without limitation, the services for dispute resolution described in subsection 3 of NRS 232.462; and (f) Contact information for any other state or local entity that investigates complaints concerning the abuse or neglect of patients. 4. In addition to the requirements of subsections 1, 2 and 3, every hospital shall, upon the discharge of a patient from the hospital, provide to the patient or the patient's legal representative a written	1240	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation pertaining to resident's rights, Resident #1, Resident #3, Resident #9 and Resident #10 have documentation of resident's rights in their resident's file . 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator will maintained residents records for each resident and audit and update the files so that all requirements will be met and carried on. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will maintain residents records in the residents file and audit and update the files constantly so that all the requirements will be met and carried on at all times. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective action will be completed. The corrective action was completed on January 27, 2025. 6. You must attach all supporting documents into the system. ATTACHMENT 8 7. How you will identify and correct other areas having potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	01/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2973	A. BUILDING _____ B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	disclosure approved by the Director, which written disclosure must set forth: (a) If the hospital is a major hospital: (1) Notice of the reduction or discount available pursuant to NRS 439B.260, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount under that section; and (2) Notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, which policies and procedures are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260. The notice required by this subparagraph must describe the criteria a patient must satisfy to qualify for the additional reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment. (b) If the hospital is not a major hospital, notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons. The notice required by this paragraph must describe the criteria a patient must satisfy to qualify for the reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment. As used in this subsection, "major hospital" has the meaning ascribed to it in NRS 439B.115. 5. In addition to the requirements of subsections 1 to 4, inclusive, every hospital shall post in a conspicuous place in each public waiting room in the hospital a legible sign or notice in 14-point type or larger, which sign or notice must: (a) Provide a brief description of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, including, without limitation: (1) Instructions for receiving additional information regarding such policies and procedures; and (2) Instructions for arranging to make payment; (b) Be written in language that is easy to understand; and (c) Be written in English and Spanish.			

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	(Added to NRS by 1983, 822; A 1985, 1749; 1999, 1053, 3252; 2003, 1880; 2005, 947; 2011, 362, 697; 2019, 537, effective January 1, 2020) Inspector Comments: Based on interview and record review, the facility failed to ensure residents were informed of resident's rights upon admission for 4 of 10 residents (Resident #1, #3, #9, and #10). Findings include: Resident #1 (R1) R1 was admitted to the facility on 09/01/24, with diagnoses including Alzheimer's and kidney disease. R1's file lacked an admission agreement which documented the resident being informed of residents' rights upon admission. Resident #3 (R3) R3 was admitted to the facility on 03/16/24, with a diagnosis of dementia. R3's file lacked an admission agreement which documented the resident being informed of their residents' rights upon admission. Resident #9 (R9) R9 was admitted to the facility on 11/27/24, with diagnoses including dementia and kidney failure. R3's file lacked an admission agreement which documented the resident being informed of their residents' rights upon admission. Resident #10 (R10) R10 was admitted to the facility on 08/15/24, with diagnoses including chronic kidney disease and hypertension. R10's file lacked an admission agreement which documented the resident being informed of their residents' rights upon admission. On 01/22/25 in the morning, the Administrator confirmed the facility's admission documents did not include informing residents or their legal representative upon admission about resident's rights for R1, R3, R9 and R10. Severity: 2 Scope: 2			