Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3091	A. BUILDING _____ B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGE AT PARADISE VALLEY ASSISTED LIVING	2205 EAST HARMON AVE, LAS VEGAS, NEVADA ,89119

(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 an annual State Licensure survey completed at your facility on 03/25/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 91 Residential Facility for Group beds for elderly and disabled persons to provide assisted living services, 81 Category 1 and 10 Category II residents. The census at the time of the survey was 26. Ten resident files and eight employee files 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		

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0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 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 449.156 to 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 interview and record review, the facility failed to ensure eight hours of caregiver training were completed annually, for 1 of 8 employees (Employee #1). Findings include: Employee #1 (E1) was hired on 02/15/23 as a Medication Technician. Review of E1's employee record revealed E1's last completed caregiver training was on 02/21/23. There was no documentation E1 completed eight hours of annual caregiver training for 2024 and 2025. On 03/26/25, in the morning, the Business Office Manager confirmed E1 had not completed eight hours of annual caregiver training for 2024 and 2025. Severity: 2 Scope: 1	0065	All staff and management have been educated on this State reg for annual hours of training. All staff files have been audited by Executive Director and found certificates were not physically in employee files. This has been corrected, printed, and placed in all employee files. E# 1 confirmed to have 8 hours training and E# 1 confirmed. Executive Director in-person training had been completed for all care staff to fulfill both E# 1 8-hour minimum training for the year. Executive Director and Business Office Director will ensure monthly in-service training for Caregivers to fulfill 8 hours minimum of annual training By the Bureau recommendation. This will be monitored and Measured by QMPI process Completed 3-29-2025.	03/29/2025

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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 interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) training was completed every two years for 1 of 8 employees (Employee #3). Findings include: Employee #3 (E3) was hired on 02/03/23 as a medication technician. E3 last completed CPR training on 02/21/23. There was no documentation of current CPR training on file for E3 for 2025. On 03/25/25, in the morning, the Business Office Manager confirmed E3's CPR training had expired and needed to be completed. Severity: 2 Scope: 1	0106	1. Employee#3 completed CPR First Aid on 04/08/25. Identification of Others 2. The Business Office Manager and Executive Director completed an audit of all personnel files to ensure all associates have the required first aid and CPR training. 3. Preventative Measures and Systemic Changes • To ensure compliance a tickler has been developed to ensure all employees have the appropriate first aid and CPR training. This too will help identify new trainings that are required to prevent certifications to expire. 4. Monitoring and Inclusion into QA: • During our monthly Quality Management and Performance Improvement meetings, the Resident Care Director and Business Office Manager will report the compliance of first aid and CPR training and certification of each employee. Executive Director and Business Office Manager responsible for compliance. Completed 4/8/2025	04/08/2025

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0178 SS= E	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 interior of the premises were clean and well maintained. Findings include: On 03/25/25 in the morning, a large clear plastic garbage bag, a slipper, a plastic detergent cup, three hangers, a sock, and a paper towel were observed next to and behind the two dryers and two washers in the first floor laundry room on the west side of the building. One washer was out of service. On 03/25/25 in the morning, the Maintenance Director acknowledged the items behind the washers and dryers. The in-service front-loading washing machine had a constant drip of water near the rubber ring/boot just inside the door. The rubber ring contained a heavy layer of a black substance. On 03/25/25 at 9:45 AM, the Maintenance Director identified the water drip as coming from the washing machine's water source. The Maintenance Director scraped off some of the black substance and verbalized it could be mold or soap scum. On 03/25/25 at 10:24 AM, a clear plastic bag, a washcloth and an item resembling a small chux were on the floor on the side of the washing machine in the second floor laundry room on the west side of the building. The floor near the washing machine contained dust and granular debris. The other washer in the laundry room was out of service. On 03/25/25 in the morning, the Maintenance Director acknowledged the items and debris near the washer. On 03/25/25 in the morning, the Maintenance Director expressed their intention to replace the facility's front-loader washers with top-loader washers. Severity: 2 Scope: 2	0178	A meeting was held between the Maintenance Director and Executive Director on 3/26/25 and the Maintenance Director addressed interior and exterior concerns. All Maintenance issues and concerns will be addressed in a timely manner and entered into TELs system for correction. Executive Director will do weekly and monthly inspection rounds with the Maintenance Director of the interior and exterior. They will address safety and maintenance concerns. All Laundry area have been cleaned, and washer was cleaned of all residues replaced washer that was out of order 4/7/2025.The Maintenance Director and Executive Director will ensure compliance and monitor outcome during monthly QMPI meeting. Completed 4/7/2025	04/07/2025

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0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 03/25/2025, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the dry storage room, two containers of thickened apple juice were expired on 11/19/24 and one container of thickened lemon water was expired on 12/16/24. In the reach-in cooler in the service area, a container of cottage cheese was expired on 03/16/25 and was opened on 03/24/25. b. In the reach-in cooler in the main kitchen, a container of chili was prepared on 03/01/25 and was held longer than seven days past the date of preparation. 2. Major Violations: a. There was grime build-up on the interior of the ice machine. b. There was grease and dust build-up on the cook's line ventilation hood and equipment, including heavy grease build-up on the underside of the shelf on the range. 3. Equipment and Maintenance Violations: a. The grill and right side of the griddle on the cook's line and the deli preparation refrigerator were not functioning. b. The microwave was not commercial grade or rated for sanitation. Severity: 2 Scope: 3	0255	1. With respect to how the facility will identify and take corrective action: Immediately expired foods were discarded; Ice Machine was cleaned, and Ventilation and range was scheduled prior to the evening of survey on3/27/2025. And microwave was replaced with commercial grade. Grill was repaired and serviced on 4/7/2025. A not in use sign was place on Deli Refrigerator is schedule for repaired on 4/11/2025. Deli Refrigerator was completed repair on 4/11/2025. 2. With respect to what systemic measures to be put in place to address stated concern: Training on Expired foods with the dining team was completed and training on Labeling and dating food Items and expired foods to be discarded immediately food rotation in-service 4/10/2025 3. With respect to how the plan of corrective measures will be monitored: Weekly the Dining Director will use the weekly kitchen inspection sheets to monitor the corrective measures. Any discrepancies will be corrected immediately, and associates will be educated. Kitchen inspections will be reviewed in the monthly QMPI meeting. 4. Dining Director will be responsible for the plan of correction. Completed 4/10/25	04/10/2025

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0393 SS= D	Safety Requirements - NAC 449.226 Safety requirements for residents with restricted mobility or poor eyesight; water hazards; auditory systems for bathrooms and bedrooms; access by vehicles. (NRS 449.0302) 4. In a residential facility with more than 10 residents: (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored by a member of the staff of the facility. (b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower. (c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident's bathroom call bell was functional (Resident #10). Findings include: Resident #10 (R10) R10 was admitted on 02/16/23 with diagnoses including diabetes and hypertension. On 03/25/25 in the morning, the pull cord for R10's bathroom call bell was not set in the active position. The Maintenance Director reset the wall switch for the pull cord in the resident's bathroom, and the cord was pulled repeatedly to test the call bell response on the facility's alerting devices which were monitored by two surveyors, the Maintenance Director and the Caregiver. The Maintenance Director determined the action of pulling the pull cord was not registering on the facility's alerting devices. On 03/25/25 in the morning, R10 verbalized they did not know where their alert system pendant was currently located. On 03/25/25 in the morning, the Maintenance Director and the Caregiver acknowledged the call bell for R10's bathroom was not functioning. Severity: 2 Scope: 1	0393	1. What actions will be taken to correct the rule violation for each example/resident? A meeting was held between the Maintenance director and Executive Director on 3/28/25 and the Maintenance director addressed interior and exterior concerns. R # 10 Pulled Cords were reprogrammed and re-tested and has been corrected and new audit are in place. 2. How will the system be corrected so this violation will not happen again? All Maintenance issues and concerns will be addressed in a timely manner and entered into TELs system for correction along with monthly audits of call lights are working correctly. 3. How often will the area needing correction be evaluated? Executive director will do monthly inspection rounds with the Maintenance director of the interior and exterior. They will be addressed at the safety and any maintenance concerns. 4. The Maintenance Director and Executive Director and Care Staff will ensure compliance and monitor outcomes during the monthly QMPI meeting. Corrected 3/28/2025.	03/28/2025
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 -	0878	1.With respect to tag 0878;	03/28/2025

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	Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (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		Medications/OTC - Supplements and Change Orders 2.With respect to how the facility will identify and take corrective action: Immediately medication list was sent to the physician for clarification. Received clarification orders with d/c R# 3 11/2024 nitroglycerin 0.3 mg of medications for residents and / or refills for medications that continued. Medications ordered through pharmacy and received. 3. With respect to what systemic measures to be put in place to address stated concern: Training and Inservice with med techs on OTC medications; orders, refills, clarifications, and medications to be in building within 5 days. Resident Care Director and Administrator will ensure that OTC medications are available for the resident within 5 days of receiving an order or change in order. 4.With respect to how the plan of corrective measures will be monitored: The Resident Care Director will monitor the physician orders to ensure the med management policy is followed. Resident Care Director will review the missed med report daily and follow up per company policy. All med management concerns will be reviewed in QMPI monthly meeting. 5. Resident Care Director will be responsible for the plan of correction. 6. Completed 3/28/25.	

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	record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure medications were on site and available for administration for 1 of 10 sampled residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 04/24/24, with a diagnosis of atrial fibrillation and Parkinson's disease. R3's March 2025 Medication Administration Record (MAR) documented nitroglycerin 0.3 milligram tablet sublingual, dissolve one tablet sublingually at the onset of chest pain. If no relief, may repeat two more times with five minutes in between each dose. If no relief seek medical aid. Nitroglycerin 0.3 milligram tablet sublingual was not available or onsite for administration to R3. No physician orders were available or confirmed for administration or discontinue of nitroglycerin 0.3 milligram tablet sublingual for R3. On 03/25/25 in the morning, the Medication Technician confirmed that the nitroglycerin 0.3 milligram tablet sublingual for R3 was not available and on-site for administration. Severity: 2 Scope: 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (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; (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	0895	1. Resident Care Director has done an audit of all noted residents' medications, to ensure accuracy. All residents that have orders and medications have signed proper documentation. 2. How will the system be corrected so this violation will not happen again? Resident Care Director or designee will conduct monthly medication audits. Resident Care Director did Inservice Training with all Med techs. Resident # 8 ferrous sulfate 325 milligrams D/C on 3/6/25 1tab daily. Senna 6.6 milligrams 1tab daily also D/C. 3/6/25. 3. How often will the area needing correction be evaluated? Resident Care director will verify orders are placed in the MAR correctly as orders are received. All self-administration residents will be entered into the MAR properly.	03/28/2025

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	an order or prescription of a resident ' s physician, physician assistant 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. Inspector Comments: Based on interview, observation and record review, the facility failed to ensure the Medication Administration Record (MAR) included accurate documentation for 1 of 10 sampled residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted on 11/30/23 with diagnoses including chronic kidney disease and hypertension. R8's record revealed a Physician's order dated 01/15/25 documented Senna 8.6 milligram tablet, take one tablet by mouth once daily and a Physician's order dated 03/12/25 documented ferrous sulfate 325 milligram, take one tablet by mouth twice daily. On 03/25/25 in the morning, R8's medication bin contained a medication package labeled Senna 8.6 milligram tablet, take one tablet by mouth once daily and a medication package labeled ferrous sulfate 325 milligram, take one tablet by mouth twice daily. R8's March 2025 MAR lacked documented evidence of Senna 8.6 milligram tablet, take one tablet by mouth once daily and ferrous sulfate 325 milligram, take one tablet by mouth twice daily. On 03/25/25 in the morning, a Medication Technician acknowledged R8's MAR was incorrect and confirmed R8 was not given Senna 8.6 milligram tablet daily as physician ordered and R8 was not given ferrous sulfate 325 milligram, take one tablet daily as physician ordered. Severity: 2 Scope: 1		4. Who will be responsible to see that the corrections are completed/monitored? Resident Care Director and Executive Director will ensure compliance and monitor outcome during monthly QMPI meetings. Completed 3/28/2025	

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure a two-step tuberculosis (TB) test was completed for 1 of 10 sampled residents. (Resident #4) Findings include: Resident #4 (R4) R4 was admitted to the facility on 05/31/2024 with a diagnosis of Chronis Obstructive Pulmonary Disease (COPD). R4's medical record lacked documented evidence a two-step TB test was completed. On 03/25/2025 in the morning, the Med Tech and Business Office Manager both indicated a two-step TB test was required at the time of admission and acknowledged R4 had not completed a two-step TB test. Severity: 2 Scope: 1	0936	R4 - Tb test was not completed by facility and Chest Xray was done by former Hospice versus 2-Step Tb test. A annual questionnaire was completed on 04/16/25. R4 was given a Chest X-ray on 6/6/24 because she had a history of prior positive TB Test. R4 moved in transferring from home with hospice to ALF. Resident Care Director will ensure this requirement is in place for all residents upon future move ins and checked off on move-in checklist. This will be monitored and measured by QMPI process Completed 3/28/2025.	03/28/2025

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THE BRIDGE AT PARADISE VALLEY ASSISTED LIVING	2205 EAST HARMON AVE, LAS VEGAS, NEVADA ,89119

(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
1840 SS= E	UNL Caregiver Training - R063-21 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 interview and record review, the facility failed to ensure Infection Control training, for unlicensed staff, was completed within one year of hire, for 3 of 8 employees (Employee #1, Employee #5 and Employee #8). Findings include: Employee #1 (E1) E1 was hired on 02/15/23 as a Medication Technician. There was no documented Infection Control training found in the record of E1. Employee #5 (E5) E5 was hired on 02/09/23 as a Medication Technician. There was no documented Infection Control training found in the record of E5. Employee #8 (E8) Employee #8 (E8) was hired on 04/08/23 as a Medication Technician. There was no documented Infection Control training found in the record of E8. On 03/25/25 in the morning, the Business Office Manager was unable to provide documentation of completed Infection Control training for E1, E5 and E8. Severity: 2 Scope: 2	1840	1. Corrective Action for Identified Deficiency: · All care staff who were found non-compliant with infection control training have completed E # 1, E # 5, E # 8, the required training as of 4/10/2025. · Documentation of completion is maintained in employee files and Tracked by the Business Office Manager. 2. Measures to Prevent Recurrence: · Implement a standardized infection control training module for all new hires during onboarding. Or within 30 days of hire. · Require annual refresher training for all staff, including updates on current infection control practices (e.g., hand hygiene, PPE use, cleaning protocols). 3. Monitoring and Quality Assurance: · The Infection Control Resident Care Director will audit training records Quarterly to ensure compliance. · Reports will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee quarterly. 4. Responsible Party: · Resident Care Director and Executive Director or Infection Preventionist will be responsible for implementing and maintaining this plan. 5. Date of Completion: · Full implementation of the corrective actions and Training will be completed by 4/14/2025.	04/14/2025