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
	333	A. BUILDING _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	2305 IVES COURT, RENO, NEVADA ,89503

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 07/16/2025. This survey was conducted by the Health Care Purchasing and Compliance Division in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 60 Residential Facility for Group beds for elderly or disabled persons, and/or persons with mental illness, with assisted living services, Category II residents. The census at the time of the survey was 41. Fifteen resident records and eleven employee records were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Health Care Purchasing and Compliance Division shall not be construed as prohibiting any criminal or civil investigation, 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		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: AMY ROUKIE | Title: Administrator | Date: 10/30/2025

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, record review, personnel record review and interview, the Administrator failed to provide oversight and direction for employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAGs Y0065, Y0072, Y0074, Y0102, Y0104, Y0451, Y0872, Y0876, Y0878, Y0895, Y0926, Y0938, Y1300, Y1810, and Y1840. Severity: 2 Scope: 3	0050	1) This deficiency has been addressed as the Administrator changed as of 8/1/2025. The former Administrator was non-compliance and therefore the facility did not meet the requirements. 2) Business Office Manager (BOM)/HR and/or designee is pulling a report at least monthly to determine if any re-certification or required training is due and is completed by staff. 3) The occurrence will be monitored internally by the Business Office Manager/HR and the Corporate HR Manager. The organization as a whole is now putting systems in place to ensure this cannot occur in other locations. 4) Executive Director/Administrator is responsible for ensuring compliance along with the Business Office Manager/HR Manager. Additionally, Corporate HR will ensure communication about any missing or soon-to-expire requirements are addressed prior to the expiration. 5) The date the corrective action was corrected as of 8/1/2025 with the appointment of the currently licensed Administrator. 6) License of the current Administrator is attached. 7) Any changes in Administrator will require the completion and maintenance of all licensing requirements, training and other requirements as defined by this regulation. If there are other situations where a temporary Administrator is assigned to a facility, they must meet all standards and maintain them throughout any coverage period. 8. n/a	08/01/2025

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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 personnel record review and interview, the facility failed to ensure 1 of 11 sampled employees received the required 4 hours of initial caregiver training (Employee #6). Findings include: Employee #6 Employee #6 was hired by the facility as Medication Aide with a start date of 09/13/2024. Employee #6's personnel file lacked documented evidence of initial caregiver training completed within 60 days of hire. On 07/16/2025 at 1:06 PM, the Business Office Manager verbalized caregiver training was to be completed within 60 days of hire and confirmed Employee #6 did not have initial caregiver training completed within 60 days of hire. Severity: 2 Scope: 1	0065	1. All required caregiver trainings had been completed but were not adequately documented for the 1 employee referenced in the cited deficiency. This documentation was added to the employee's file. An audit of all required employee training was completed on 6/1/2025, and then additionally on 7/18/2025. No other issues were noted. 2. The Business Office Manager (BOM) is responsible for managing the tracking of employee training; however, the Wellness Director is specifically responsible for Caregiver training. We utilize a new hire checklist which we attach to each personnel file to aid in ensuring compliance with all required licenses and screenings. 3. BOM/HR, WD and/or designee will perform a quarterly audit with review by Executive Director to ensure compliance moving forward. 4. The Business Office Manager (BOM) and/or designee is conducting an employee file audit of all new hires to ensure all required training has been completed. 5. 06/01/2025 6. Proof of training of the employee noted, is attached, and a copy of the new hire checklist is also attached. 7. See monitoring practice under Numbers 2 and 3 above. 8. N/a	07/18/2025

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0072 SS= D	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure annual medication management training was completed timely for 1 of 11 sampled employees (Employee #2). Findings include: Employee #2 Employee #2 was hired on 02/01/2012, as the Wellness Director. Employee #2's personnel record documented Employee #2 completed annual medication management training on 10/31/2023 and 01/24/2025. The annual training for 2024 was completed 84 days late. On 07/16/2025 at 2:21 PM, the Business Office Manager confirmed medication management training was required to be completed annually and acknowledged Employee #2's medication management training for 2024 had been completed late. Severity : 2 Scope : 1	0072	1. The employee noted was not in a position of direct care during the dates noted on this survey. The attached document shows she was working as the Family Advisor (or Marketing) position during the lapse in Med Tech licensure noted on this tag. As of 2/24/2024 she was assigned that Marketing position until 1/28/2025. This is the timeframe noted as the lapse of the medication tech certification. She was re-certified on 1/24/2025 prior to returning to the position in Wellness on 1/28/2025. 2. The tracking of all training and certifications is managed by our Business Office Manager, (BOM) who notifies all who are required to schedule in advance for this training program. This was not something that should have been problematic as it was not lapsed based on her role. 3. Monthly training audits to be completed by the BOM and reviewed by the Administrator. 4. BOM and Administrator as responsible. 5. This was completed prior to the survey based on job history- there was no reason for the finding as of the date of the survey. 6. Documentation of her job history is attached. 7. This is not a deficiency, however training for all staff is monitored monthly. 8. n/a	01/25/2025
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive;	0074	1. This finding is related to the named Administrator being out of compliance at the time of the audit. The named Administrator	08/01/2025

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	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 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		was changed, and the current one has been trained in this and all other required areas. 2. As with all other training requirements, the Business Office Manager is responsible for managing all training requirements for employees. The BOM is pulling a report monthly to determine any trainings that are expiring and need completion for all employees. 3. The BOM/HR and/or designee will perform quarterly audits with review of the findings by the Executive Director to ensure compliance moving forward. As with all other employees, this training will be monitored for all employees to ensure no deficiencies occur. 4. BOM and/or their designee is responsible for managing all training compliance with oversight from the Administrator. Tracking if all new- hire and renewal training is being organized so as not to allow any future issues. 5. This was corrected by the change in Administrator 8/1/2025. 6. Documentation of training for the current Administrator is attached. 7. Ongoing monthly training audits are being conducted; see numbers 2 & 3 above. 8. n/a	

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	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 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			

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	pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure annual elder abuse prevention training was completed timely for 1 of 11 sampled employees (Employee #1). Findings include: Employee #1 Employee #1 was hired as the Administrator on 05/08/2023. Employee #1's personnel record included elder abuse prevention training completed on 02/01/2024 and 03/01/2025, 28 days after the elder abuse training was due. On 07/16/2025 at 1:21 PM, the Business Office Manager verbalized all employees were required to complete elder abuse prevention training annually. The Business Office Manager confirmed Employee #1 lacked timely annual elder abuse prevention training completed. Severity: 2 Scope: 1			

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on employee record review and interview, the facility failed to ensure annual tuberculosis (TB) screenings had been completed for 1 of 11 sampled employees (Employee #10), pursuant to Nevada Administrative Code, Chapter 441A.375. Findings include: Employee #10 Employee #10 was hired on 06/17/2025 as a Caregiver. Employee #10's record documented a QuantiFERON TB screening with a final report determination date of 06/19/2025, and a positive result. Employee #10's record lacked documented evidence of a chest x-ray and signs and symptoms had been completed upon hire. On 07/16/2025 at 1:10 PM, the Business Office Manager (BOM) confirmed a chest x-ray and signs and symptoms had not been completed for Employee #10. The BOM verbalized when an employee had a positive TB test, a chest x-ray would need to be completed and signs and symptoms. Severity: 2 Scope: 1	0102	1. This employee is no longer working for our organization; however, the practice for any employees with a positive TB result to then trigger a TB screening form and then order a chest x-ray to confirm. This employee was sent for an x-ray however, resigned prior to completion of that process. Therefore, we can confirm that with others we do have the correct process in place, yet it was not completed for this employee. 2. The Business Office Manager (BOM) is responsible for the management of this process and has been reminded to complete this for all who test positive. All new hire's TB tests are reviewed by the BOM or designee to ensure this practice is followed every time. The BOM received additional training on this process at the time of the findings. 3. The BOM or designee will perform quarterly audits with review by the ED to ensure compliance moving forward. 4. The BOM or their designee is responsible for managing the hiring process and for tracking of employee screening with ongoing monitoring by the Executive Director. 5. All staff records were reviewed against the new hire checklist as of 7/18/2025, to confirm there were no additional instances of this issue occurring. 6. Attached document is supportive of termination of the employee. 7. There is one other employee who has tested positive and has followed these steps in the past and will in the future.	07/18/2025

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 11 sampled employees had a background check clearance through the Nevada Automated Background Check System (NABS) for this facility. (Employee #1) Findings include: On 07/16/2025 at 6:00 AM, the facility's NABS account lacked documented evidence of Employee #1 being entered and cleared. Employee #1 Employee #1 was hired on 05/08/2023 as the Administrator. Employee #1's file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 07/16/2025 at 1:10 PM, the Business Office Manager confirmed there was no NABS Clearance letter for Employee #1 and it was for another facility. Severity: 2 Scope: 1	0104	1. This employee was the named Administrator at the time of the survey however had background check results assigned to a different facility located in Las Vegas, rather than this facility. This person is no longer employed by the organization since the change in Administrator as of 8/1/2025. 2. The BOM and/or their designee are responsible for ensuring the background checks assigned to Park Place in the NABS system. All employees have been audited to determine that all who work in the facility are screened for criminal history prior to employment commencing. 3. Ongoing and monthly record reviews for employees are completed by the BOM and reviewed by the Administrator who also can review them in the state NABS system. 4. The BOM and Administrator are responsible for this function. 5. All items related to the Administrator's lack of licensure requirements were corrected with the change occurring on 8/1/2025 to a new Administrator. 6. Administrator's background check is attached. 7. All employee background checks are maintained by the BOM; this was an exception and will not occur again.	08/01/2025

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0451 SS= F	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure first aid kits contained the required supplies. Findings include: On 07/16/2025, the following first aid kits did not contain all required items. At 10:40 AM, the first aid kit in the Brown Cottage did not contain roller gauze, gauze pads, adhesive tape, or adhesive bandages. At 10:56 AM, the first aid kit in the Yellow Cottage did not contain roller gauze, gauze pads, or adhesive tape. At 11:26 AM, the first aid kit in the White Cottage did not contain roller gauze, gauze pads, adhesive tape, or scissors. At 11:46 AM, the first aid kit in the Gray Cottage did not contain roller gauze, gauze pads, adhesive tape, adhesive bandages, or scissors. At 11:54 AM, the first aid kit in the Blue Cottage did not contain roller gauze or scissors. On 07/16/2025, at 11:20 AM, the Medication Technician (Med Tech) verbalized the first aid kits that were often used by caregivers for use on residents during normal activities, not just for emergency purposes. On 07/16/2025, the Maintenance Supervisor confirmed that each first aid kits did not contain all of the required supplies. Severity: 2 Scope: 3	0451	1. At the time of the survey, first aid kits were in 5 locations for better access in this community. Based on that, there were 5 that require replenishment and restocking and unfortunately, that process has been difficult to follow, and therefore, has been discontinued with one being maintained in the main office moving forward. The standard provides for 'A' First Aid kit and although missing some items, since we had 5 located throughout the community. This was treated as there were five separate incomplete kits. We will now ensure one is filled properly only and maintained moving forward. 2. the community has one person/position that is now accountable and will ensure the kit is completed with a daily audit to confirm it contains all items required. 3. Monitoring of this kit will be the responsibility of Wellness as it relates to their needs for access to supplies for their employees. 4. Wellness Director is responsible for this item and will need to provide oversight. 5. This was completed by 7/18/2025 based on the survey results and recommendations. 6. We have now one kit with the list found on the interpretive guidelines attached. 7. Wellness Director will ensure this is maintained by checking it once weekly herself or her designee. 8. n/a	07/18/2025

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0872 SS= D	Medication Educ Initial/annual Administrator - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (f) In his or her first year of employment as an administrator of the residential facility, receive, from course approved by the Division pursuant to section 12 of this regulation, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training. (g) After receiving the initial training required by paragraph (f), receive annually from a course approved by the Division pursuant to section 12 of this regulationat least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure the annual medication management training was completed for 1 of 11 sampled employees (Employee #1). Findings include: Employee #1 Employee #1 was hired on 05/08/2023, as the Administrator. Employee #1's personnel record documented Employee #1 completed eight hours of medication management training on 05/17/2024 and on 06/05/2025, 19 days late. On 07/16/2025 at 1:10 PM, the Business Office Manager confirmed Employee #1's medication management training was completed late. Severity: 2 Scope: 1	0872	1. The cited employee is no longer employed with the organization, so this deficiency has been corrected through the installment of the new Administrator. This change was effective as of 8/1/2025 and all requirements have been met. 2. Business Office Manager (BOM)/HR and/or their designee is pulling a report monthly, or more frequently to determine if any re-certifications or required trainings are coming up for renewal, so that the staff can be advised and prompt results can follow. 3. BOM/HR, Wellness Director or designee, will perform a quarterly audit with review by the Executive Director to ensure compliance moving forward. 4. The BOM is responsible for managing the tracking of employee training with ongoing monitoring and accountability by the Executive Director. 5. 8/1/2025 6. N/A 7. See monitoring practices under numbers 2 and 3 above. 8. N/A	08/01/2025

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure an ultimate user agreement was completed for 1 of 15 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 05/04/2025, with diagnoses including Parkinson's disease and unspecified dementia. Resident #7's clinical record documented a signed ultimate user agreement, however lacked the date the agreement was signed by the resident and the facility. On 07/16/2025 at 11:40 AM, the Wellness Coordinator confirmed Resident #7's ultimate user agreement lacked the dates the agreement was signed prior to the facility possessing and/or administering resident medication. Scope: 2 Severity: 1	0876	1. The Resident has an Ultimate User Agreement in place with their admission paperwork however, it had not been dated when signed by the Wellness Director as required. That has been resolved as of the day after the survey. 2. The Wellness Director and/or designee will review all new admission files to ensure required documentation has been completed. There is a new admission checklist that is utilized to ensure all documents are available in the file. 3. In addition to completing a review of new admission files, the Wellness Director and/or designee will conduct an audit of a random percentage of resident records will be completed at least quarterly to identify any issues. Executive Director will review findings. 4. Resident Care Coordinator, Wellness Director and/or designee. 5. 7/18/2025. 6. The signed and dated agreement is attached. 7. See the monitoring practice noted in numbers 2 and 3 above. 8. n/a	07/18/2025
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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	0878	1. Issues with this resident has been resolved as of the day of the survey. All medications were obtained and administered as required. 2. We implemented a 'red dot/green dot' system to communicate when the medications are re-ordered and/or if received, are held in the locked medication room for when the current supply has exhausted. Red dots are added to the medication cards or bottles when medications are nearly depleted. When reordered, this dot is added to the medication cards illustrating the action of reordering of the medications has occurred. We then add green dots to the	07/18/2025

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	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 record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, clinical record review, interview, and document review, the facility failed to ensure 1) medications were onsite and able to be administered for 2 of 15 sampled residents (Resident #6 and #15), and 2) a change label was affixed to a resident's medication container for 2 of 15 sampled residents (Resident #15 and #12). Findings include: Medications onsite Resident #6 Resident #6 was admitted to		medication cards or bottles once medications are received and held in stock in the medication room. An in-service was provided on all areas related to re-ordering and tracking on medications to Med-Techs on 7/18/2025. A med-cart audit was completed on 7/18/2025 by the Med Techs with any identified issues between orders, MAR and inventory on med-carts resolved. 3. Weekly medication cart audits are performed by the Wellness Director and/or designee for the next 5 days and if substantial compliance is observed, periodically thereafter. 4. Wellness Director and/or designee with oversight by the Executive Director. 5. Refresher training was provided on 7/18/2025 by the Wellness Director and will be repeated quarterly or more frequently as indicated. 6. See medication administration policy attached and documentation of the Med Tech refresher training. 7. See monitoring practices noted under numbers 2 and 3. 8. N/A	

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	the facility on 03/18/2025, with diagnoses including essential hypertension (HTN) and hyperlipidemia. A Medication Verification Form, dated 03/08/2025, included the following physician's orders: -Acyclovir 200 milligram (mg) tablet. Take one tablet by mouth every day for herpes prophylaxis. -Benazepril 20 mg tablet. Take one tablet by mouth every day for hypertension. Resident #6's July 2025 Medication Administration Record (MAR) documented the following: -Acyclovir oral capsule 200 mg. Give one capsule by mouth in the evening for prophylaxis for herpes. -Benazepril Hydrochloride (HCl) oral tablet 20 mg. Give one tablet by mouth in the evening for HTN. On 07/16/2025 at 12:57 PM, during a review of Resident #6's medications, the Acyclovir and Benazepril were not present. On 07/16/2025 at 12:57 PM, a Medication Technician (Med Tech) confirmed the medications were listed on the resident's MAR, however, were not included among Resident #6's medications. The Med Tech explained the Med Techs were responsible for requesting medication refills from the pharmacy seven days prior to the expected last administration. The Med Tech verbalized the facility lacked documentation Acyclovir and Benazepril refills were requested. Resident #15 Resident #15 was admitted to the facility on 12/13/2020, with diagnoses including vitamin deficiency and depression. A Supplemental Physician's Order form, dated 07/10/2025, included the following physician's orders: -Fluoxetine 20 mg. Take 20 mg, by mouth once a day for depression. -Multiple Vitamin tablet. Take one tablet by mouth once a day for supplement. -Tamsulosin 0.4 mg. Give 0.4 mg, by mouth once a day for benign prostatic hyperplasia (BPH). Resident #15's July 2025 MAR documented the following: -Fluoxetine HCl oral tablet 20 mg. Give one tablet by mouth one time a day for depression. -Multiple Vitamin tablet. Give one tablet by mouth one time a day for vitamin deficiency. -Tamsulosin HCl capsule 0.4 mg. Give one capsule by mouth one time a day for prostatic hyperplasia. On 07/16/2025 at 1:34 PM, during a review of Resident #15's medications, the Fluoxetine, Multiple Vitamin, and Tamsulosin were not			

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	present. On 07/16/2025 at 1:34 PM, the Med Tech confirmed the medications were listed on the resident's MAR; however, they were not included among Resident #15's medications. The Med Tech explained the last dose of all missing medications were administered in the morning of 07/16/2025, and a refill was requested on 07/15/2025, one day before the last doses were administered. On 07/16/2025 at 3:05 PM, the Wellness Coordinator verbalized staff were expected to request medication refills from the pharmacy seven days prior to the last dose administered. The Wellness Coordinator explained all resident medications needed to be onsite. The facility policy titled "Revised Medication Management Plan," undated, documented each resident's prescription medications and any over the counter drugs would be filled in a timely manner to avoid missed dosages. All medications refills would be requested when the resident's medication got down to seven days. Change label Resident #15 A Supplemental Physician's Order form, dated 07/10/2025, included a physician's order for Humalog Kwik pen (Insulin Lispro) subcutaneous (SC) injection. Administer 18 units in the morning. Resident #15's July 2025 MAR documented Humalog Kwik pen subcutaneous solution pen injector 100 units/milliliter (mL). Inject 18 units subcutaneously in the morning for diabetes. On 07/16/2025 at 1:34 PM, during a review of Resident #15's medications, and in the presence of a Med Tech, included among Resident #15's medications was a bag labeled Insulin Lispro 100 mL. Inject 18 units subcutaneously three times a day before meals. On 07/16/2025 at 1:34 PM, the Med Tech confirmed Resident #15's MAR documented to administer Insulin Lispro one time a day in the morning, while the medication label documented to administer Insulin Lispro three times a day before meals. The Med Tech verbalized medication labels should match the MAR and physician's order. Resident #12 Resident #12 was admitted to the facility on 11/25/2023, with a diagnosis of pain and constipation. A Supplemental Physician's Order form, dated 06/04/2025, documented			

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	Senna plus 8.6/50 milligrams (mg). Give one tablet by mouth once daily as needed for constipation. A Supplemental Physician's Order form, dated 07/11/2025, documented Morphine 20 mg/mL. Take 0.25 mL, by mouth every two hours as needed for pain or shortness of breath. Resident #12's July 2025 MAR documented the following: -Senna Plus oral tablet 8.6-50 mg. Give one tablet by mouth as needed for constipation. -Morphine Sulfate concentrate oral solution 20 mg/mL. Give 0.25 mL, by mouth every one hour as needed for pain or shortness of breath. On 07/16/2025 at 12:14 PM, during a review of Resident #12's medications and in the presence of a Med Tech, the following medications were present: -Senna Plus 8.6-50 mg tablet. Take one tablet twice daily as needed for constipation. -Morphine Sulphate 100 mg/5 mL. Give 0.25 mL, by mouth every one hour as needed for pain. On 07/16/2025 at 12:14 PM, the Med Tech confirmed the Senna Plus and Morphine did not match the physician's order. The Med Tech verbalized the Med Tech should have gotten clarification, and a change order label should have been affixed to the medication containers to match the physician's order. On 7/16/2025 at 3:05 PM, the Wellness Coordinator verbalized the medication labels, MAR, and physician's orders should match. The facility policy titled "Revised Medication Management Plan," undated, documented when medications were delivered, the facility would ensure the correct medication arrived and the medication, electronic medication administration record, and the physician's order were all the same. 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	0895	1. The medication issues with this Resident (admitted on 3/18/25) was resolved through discussion with the provider and the pharmacy the same day. Resident #12 admitted 11/25/2023 was on Hospice care at the time of the review and changes to the dose and frequency of the Morphine occurred frequently due to the resident being in active transition to dying. The Hospice staff were monitoring Resident closely and had discontinued the Morphine	07/18/2025

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	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 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 observation, interview, clinical record review, and document review, the facility failed to ensure a current medication order was accurately reflected on the resident's Medication Administration Record (MAR) for 2 of 15 sampled residents (Resident #6 and #12). Resident #6 Resident #6 was admitted to the facility on 03/18/2025, with diagnoses including essential hypertension (HTN) and hyperlipidemia. A Medication Verification form, dated 03/08/2025, included a physician's order for Calcium Carbonate - Cholecalciferol (Cal Carb-Cholecal) 600 mg/10micrograms (mcg). Give one tablet by mouth every day. Resident #6's July 2025 MAR lacked documentation of the Cal Carb-Cholecal. On 07/16/2025 at 12:57 PM, during a review of Resident #6's medications, Cal Carb-Cholecal was present. On 07/16/2025 at 12:57 PM, a Medication Technician (Med Tech) confirmed Cal Carb-Cholecal was not documented on the resident's MAR and verbalized it should have been. The Med Tech explained resident medications should be documented on the MAR to ensure necessary medications are administered. The Med Tech verbalized the facility lacked a discontinue order for Resident #6's Cal Carb-Cholecal. Resident #12 Resident #12 was admitted to the facility on 11/25/2023, with a diagnosis of pain and constipation. A		once a new order was written. 2. Medication reviews are complete daily on all shifts by Med Techs. Med-Techs have received a refresher in-service training to ensure they are aware of this process and how to ensure there are no discrepancies in orders, each time they are passing meds. 3. Wellness Director and the Resident Care Coordinator implemented a weekly audit to monitor medications received daily. The Pharmacy also reviews our medications quarterly. 4. Wellness Director, or designee with oversight by the Administrator 5. Training was completed by 7/18/2025 to refresh the understanding of this process and to ensure no future incidents occur. 6. Attached are the documents utilized in the refresher medication administration training. 7. Maintain closer review of those with changing medication orders based on changing care or Hospice status. 8. n/a	

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	Supplemental Physician's Order form, dated 07/11/2025, documented Morphine 20 mg/mL. Take 0.25 mL, by mouth every 2 hours as needed for pain or shortness of breath. Resident #12's July 2025 MAR documented Morphine Sulfate concentrate oral solution 20 mg/mL. Give 0.25 mL, by mouth one every one hour as needed for pain or shortness of breath. On 07/16/2025 at 12:14 PM, during a review of Resident #6's medications, the following medications were present: -Morphine 20 mg/mL. Take 0.25 mL, by mouth every two hours as needed for pain or shortness of breath. -Morphine Sulphate 100 mg/5 mL. Give 0.25 mL, by mouth every one hour as needed for pain. On 07/16/2025 at 12:14 PM, the Med Tech verbalized medication cart audits were performed every three months to ensure resident MARs, medication labels, and physician's orders matched. The Med Tech explained the MAR and medication labels should match to ensure the correct medication was given at the correct dose. The Med Tech confirmed Resident #12's MAR did not match the medication label for Morphine and explained the Med Tech should have reached out for clarification from the physician. On 07/16/2025 at 3:05 PM, the Wellness Coordinator explained all resident medication should be documented on the MAR to ensure the facility was aware of the medications a resident was expected to be taking. The Resident's MAR should match the medication label and order. The facility policy titled "Revised Medication Management Plan," undated, documented when the facility received an order, the Med Tech would input the order into the MAR and place the order in a communication tray. Each order would then be reviewed in the electronic medication administration record for accuracy. Severity: 2 Scope: 1			

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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 record review and interview, the facility failed to ensure 1 of 15 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 05/04/2025, with diagnoses including Parkinson's disease and unspecified dementia. Resident #7's clinical record documented a two-step TB. The first step was administered on 03/19/2025; however, lacked the date the TB was read negative. The second step was administered on 04/07/2025; however, lacked the date the TB was read negative. On 07/16/2025 at 11:40 AM, the Wellness Coordinator verbalized residents were required to complete a two-step TB upon admission to the facility. The second-step needed to include the date of administration and a reading date within 72 hours. The Wellness Coordinator confirmed Resident #7's two-step TB test lacked reading dates on both steps of administration and could not determine if the TB test was completed due to the missing information. Severity: 2 Scope: 1	0936	1. Resident #7 (F.E.) was cleared for TB prior to admission was provided by St. Mary's Hospice and was signed off on 5/1/2025, the time was noted when the TB was read however, no date was documented for each reading. For this resident, the Hospice Nurse has now signed off on the results with both date and time for each reading. We will ensure that all Residents entering have a clear test date and read date, and there is no entry without that documentation. 2. The Wellness Director and/or designee will review all new admission files every 30 days to ensure all required screenings are in place including the TB. the documents required for admission is the responsibility of the Wellness Director and needs to confirm this and all documents are accurate prior to admission. 3. In addition to completing a review of all new admission files, the Wellness Director and/or their designee will conduct an audit of random sampling of resident records will be completed at least quarterly to identify any issues. The Executive Director will review the findings and make recommendations. 4. Resident Care Coordinator, Wellness Director and/or their designee, under the guidance of the Administrator. 5. 7/18/2025. 6. The signed and dated document is attached noting the TB test provided prior to admission. 7. Ongoing reviews of all resident files. 8. n/a	07/18/2025

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0938 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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she 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 or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an initial ADL assessment was completed timely for 1 of 15 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 11/06/2024, with diagnoses including Alzheimer's disease, unspecified, type two diabetes mellitus, and vitamin D deficiency. Resident #5's clinical record documented an initial ADL assessment dated 12/09/2024, more than one month overdue. On 07/16/2025 at 11:38 AM, the Wellness Coordinator verbalized ADL assessments were due upon the date of admission to the facility and confirmed Resident #5's ADL assessment was completed late. Severity: 2 Scope: 1	0938	1. Review of the record of resident #5 is that the ADL assessment was completed on 11/7/2024 therefore, was not late as per this finding. See documentation attached. This documentation is a part of the ALF assessment completed at intake. Chart audits on all current residents were completed after survey. No issues with ADL assessments were noted. 2. The Wellness Director and/or designee will review all new admission files within 30 days. to ensure required ADL assessments have been completed. 3. In addition to completing a review of new admission files, Wellness Director and/or designee will conduct an audit of random sampling of resident records will be completed at least quarterly to identify any issues. Executive Director will review findings. 4. Wellness Director and Resident Care Coordinator under the direction and oversight of the Administrator. 5. The ADL assessment was included in the original ALF assessment completed upon admission, 11/17/2024. 6. See assessment for resident #5 attached. 7. See monitoring practices noted above in numbers 2 and 3. 8. N/A	11/07/2024
1810 SS= C	Infection Control Program - NAC 449.0109 Program and policy for control of infection; designation and training of person responsible for infection control. (NRS 439.200, 449.0302) 1.A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and	1810	1. Infection control plan has been signed. Records reflect immediate correction and review and approval of Infection Control plan documented in the binder, with a copy attached herein. 2. Review of this plan will occur annually of the plan, as well as at any time when there	08/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	333	A. BUILDING _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and (c) Develop and carry out a comprehensive plan for emergency preparedness. 2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on observation, document review and interview, the Administrator failed to ensure the facility's Infection Control Program was reviewed annually. Findings include: On 07/16/2025 at 11:46 AM, the facility's Infection Prevention and Control Plan, undated, was provided by the Wellness Coordinator. The Infection Prevention and Control Plan lacked documented evidence the plan was reviewed annually. On 07/16/2025 at 1:04 PM, the Maintenance Director verbalized not being sure how often the Infection Control Plan and policies were to be reviewed. The Maintenance Director explained the Executive Director		are regulatory changes, or guidance from the County Health Department. 3. The Wellness Director will perform the review of the IPP with Executive Director oversight to ensure completion. The annual review has now been scheduled. 4. The Wellness Director, Administrator and/or designee. 5. 8/1/2025 completed 6. Signed Infection Control plan. 7. Set reminders for annual review, and see items noted above in numbers 2 and 3. 8. n/a	

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	and Wellness Director reviewed the facility's Infection Prevention and Control Plan; however, lacked documented evidence of being reviewed annually. Severity: 1 Scope: 3			