STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	439	A. BUILDING _____ B. WING _____	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON SENIOR GUEST HOME	3709 W WASHINGTON AVE, LAS VEGAS, NEVADA ,89107

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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 05/19/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or persons with Mental Illness, Category II residents. The census at the time of the survey was six. Six resident files and three employee files were reviewed. The facility received a grade of A. 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		
0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure a medical exemption request was submitted to the Bureau for a resident who required wound care and Foley catheter care for 1 of 6 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 07/19/24 with a diagnosis of chronic subdural hemorrhage- terminal diagnosis and palliative care. On 05/19/25 at 9:45 AM, R4 was observed lying in bed with a catheter bag. R4 was unable to to answer questions regarding R4's catheter. On 05/19/25 in the morning, the Caregiver, Employee #1 (E1) reported R4 had a wound and was receiving wound care from a	0830	1. On June 25, 2025, Administrator submitted a Medical Exemption with HCQC with regards to R4's conditions of Wound Care and Catheter Care and was approved on June 26. 2025. 2. Upon admission, administrator shall assess resident and file a Medical Exemption Waiver if resident has restrictions for admission into a residential facility. And for existing residents, to file a Medical Exemption Waiver if their conditions change that requires a medical exemption to keep the resident in the residential facility. 3. Lead Caregiver, Owner and Administrator will continue to monitor residents that may need to apply for a Medical Exemption Waiver. 4. Administrator is responsible in ensuring that the plan of correction is implemented. 5. On June 25, 2025. 6. Please see attached document.	06/25/2025

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	hospice care agency. In a phone interview on 06/02/25, the hospice nurse from the hospice agency who provided care to R4 reported R4 had been admitted to hospice care in July 2024. The hospice nurse related that in February or March of 2025, R4 had redness and an ulcer in the sacral area which was on and off a Stage 1, and by April was reported to be progressing to a Stage 2. On April 21, 2025, the wound was reported as a Stage 3. By May 01, 2025, the wound had progressed to a Stage 4 and the hospice agency brought in the services of a wound care specialist. Per the hospice nurse, R4 received wound care for the sacral wound three times a week between the wound care specialists and hospice care. On 05/19/25 at 10:10 AM, E1 demonstrated emptying and cleaning the catheter bag. E1 indicated the Hospice Nurse came twice a week, and the Certified Nursing Assistant from the hospice agency came every day for wound care and/or catheter care. On 05/19/25 at 3:34 PM, E1 and Employee #2 (E2) confirmed E1 and E2 were the only caregivers employed by the facility who emptied the catheter bag. R4's file lacked documented evidence of an application for submission and/or an approved medical exemption for a resident who had a wound and an indwelling catheter. On 05/19/25 in the afternoon, E1 acknowledged the facility had not applied for and been approved for a medical exemption to retain R4 who had a wound and urinary catheter. Severity: 2 Scope: 1			
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.	0876	1. During the survey conducted on May 19, 2025, Owner contacted the medical provider for R3 and clarified the doctor's prescription containing a range order for Metoprolol 25mg and doctor changed the prescription to routine and without the range order. 2. Owner and Administrator will be mindful that range orders for residents are not permitted in a residential facility. 3. Lead Caregiver, Owner and Administrator will monitor all medications that "range orders' are not contained in the residents doctor's prescription. 4. Administrator is responsible in ensuring that the plan of correction is implemented.	05/19/2025

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	Inspector Comments: Based on observation, record review, and interview, the facility failed to to ensure a resident's medication did not have range orders for a blood pressure medication for 1 of 6 residents' (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 03/22/22 with diagnoses including atrial fibrillation, hypertension, gout, gastro-esophageal reflux disease (GERD), and coronary artery disease. R3's May 2025 Medication Administration Record (MAR) documented Metoprolol 25 milligram (mg) tablet, take one tablet by mouth twice a day, hold SBC (blood pressure monitor/sphygmomanometer brand) <110 or hr (heart rate) <65. R3's medication bin contained a bottle labeled Metoprolol Tartrate 25 mg tablet, take one tablet by mouth twice a day, hold for systolic blood pressure <110 or heart rate <65. On 05/19/25 in the afternoon, the facility was unable to provide a copy of the physician order for Metoprolol. On 05/19/25 at 1:54 PM, E1 reported most of the residents were able to take their own blood pressure. Per E1, the residents took their blood pressure and the caregivers administered the medication depending on the blood pressure reading and the prescription directions. On 05/19/25 at 2:00 PM, E1 and E2 verbalized they administered Metoprolol whenever R3's blood pressure was very high. They confirmed R3 took R3's own blood pressure. E2 reported they administered Metoprolol to R3 every day. E1 explained the nurse instructed the caregivers to give Metoprolol to R3 no matter what, unless the blood pressure was less than 110. In a phone interview on 05/19/25 at 2:10 PM, R3's medical provider's assistant indicated the caregivers were unable to safely administer Metoprolol to R3 without knowing R3's blood pressure, and indicated the prescription must remain as written (as a range order) to provide the proper care for R3 and to avoid medical issues. R3's prescribed Metoprolol was not clarified with the physician's office and required the caregivers to make an assessment for when to hold R3's Metoprolol based on systolic blood pressure		5. On May 19, prescription order was changed and to not have a range order. 6. Please see attached document.	

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	and/or heart rate. On 05/19/25 in the afternoon, the caregivers confirmed the physician's order was not clarified and acknowledged the medication required an assessment for blood pressure. 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 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, record review, and interview, the facility failed to ensure the instructions on the Medication Administration Record (MAR) accurately reflected the physician's prescription for 1 of 6 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 03/28/25 with a diagnosis of calf debility. R1's May 2025 MAR documented Methenamine Hippurate 1 milligram (mg) tablet, take one tablet by mouth once daily. The medication bottle in R1's medication bin was labeled with the instructions, Methenamine Hippurate 1 gram (gm) tablet, take one tablet by mouth	0895	1. On May 19, 2025, during the survey, the MAR for R1 was corrected to reflect the correct dosage. 2. Lead Caregiver / designee will be more mindful that the medication bottle's instructions matches the entry on the MAR. 3. Administrator or designee will review all resident's medications no less than once a month that instructions on medication bottle and the MAR must match exactly. 4. Administrator is responsible in ensuring that the plan of correction is implemented in order to be in compliance. 5. On May 19, 2025, MAR was corrected. And on June 2, 2025, a copy of the prescription order was sent to the surveyor. 6. No attached documents.	05/19/2025

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	once daily. The Physician Verification of Medications list dated 03/28/25 documented Methenamine Hippurate one mg, one tablet by mouth daily. The Administrator signed the document on 03/28/25, and the physician signed the document without documenting the signature date. The Administrator verbalized the document was created by the facility for the physician to sign, and admitted neither Administrator nor the physician picked up on the discrepancy of the Methenamine Hippurate dose. The facility obtained and emailed a copy of the physician prescription order for Methenamine Hippurate to the surveyor on 06/02/25. The physician order was dated 11/08/24 and documented Methenamide Hippurate one gm oral tablet, take one tablet daily. On 05/19/25 in the afternoon, the Administrator and the Caregiver acknowledged the May MAR and the medication bottle did not match for Methenamine Hippurate, and the physician order should have been checked to verify the dosage. Severity: 2 Scope: 1			

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0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured. Findings include: On 05/19/25 at 11:58 AM, the following medications were observed in the facility, unsecured: -The kitchen refrigerator contained Ozempic one milligram (mg) and Basaglar insulin pens, which were prescribed for the Caregiver. -The refrigerator in an outside building contained three boxes of Ozempic insulin pens and three boxes of Basaglar 100 units/milliliter (ml) insulin pens. The door to the outside building was propped and held open by a barbell. On 05/19/25 at 12:05 PM, the Administrator and the Caregiver acknowledged the insulin was unsecured and should have been kept in a secured area. This is a repeat deficiency from the 05/02/24 survey. Severity: 2 Scope: 3	0920	1. On May 19, 2025, during the survey, the insulin that belonged to E2 was removed from the kitchen refrigerator and placed in the employee's refrigerator in the guest house in the back yard and the door was locked. 2. Administrator explained to all caregivers that all medications stored at a residential facility must be stored in a locked area that is cool and dry. 3. Owner will conduct daily checks that all medications are stored in a locked area at all times. 4. Administrator is responsible that the plan of correction is implemented in order to be in compliance. 5. On May 19, 2025, all medications were secured in a locked area. 6. No attached documents.	05/19/2025