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
	9018	A. BUILDING _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOUSE OF SOUTHERN HILLS	**9750 W. SUNSET ROAD, LAS VEGAS, NEVADA ,89148**

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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 03/15/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 158 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and provides assisted living services, Category II residents. The census at the time of the survey was 156. Twenty Five resident files and ten employee files were reviewed. The facility received a grade of D. 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		

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: MICHAEL MASICH Title: Executive Director Date: 04/07/2025

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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 record review and interview, the facility failed to ensure 1 of 10 sampled employees had completed eight hours of initial Caregiver training. (Employee #3). Findings include: Employee #3 (E3) E3 was hired on 11/26/24 as a Caregiver. E3's employee record lacked documented evidence of eight hours of initial Caregiver training. On 03/18/25 in the afternoon, the Administrator acknowledged E3's employee record lacked documented evidence of eight hours of initial Caregiver training. Severity: 2 Scope: 1	0065	**Tag 0065** – **E3** completed **0.75hours** of caregiver training on **03/26/2025**, **2.30 hours** on**03/27/2025**, **3.25 hours** on **03/28/2025**, and **2 hours**, on **04/01/2025**. The new employees' direct supervisor will ensure that their training is completed before they work on the floor.	04/07/2025
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide	0074	**Tag 0065** – **E3** completed **0.75hours** of caregiver training on **03/26/2025**, **2.30 hours** on**03/27/2025**, **3.25 hours** on **03/28/2025**, and **2 hours**, on **04/01/2025**. The new employees' direct supervisor will ensure that their training is completed	03/31/2025

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	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 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		before they work on the floor.	

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	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 pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and record review, the facility failed to			

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	ensure annual elder abuse training was completed for 2 of 10 employees (Employee #3 and #4). Findings include: Employee #3 (E3) E3 was hired on 11/26/24 as a Caregiver. E3's file lacked documented evidence of initial elder abuse training in 2024. Employee #4 (E4) E4 was hired on 07/01/23 as a Caregiver. E4's employee file contained evidence of elder abuse training received on 06/28/23. E4's file lacked documented evidence of elder abuse training in 2024. On 03/18/25 in the afternoon, the Administrator acknowledged E3 did not complete initial and annual Elder Abuse training and E4 did not complete annual Elder Abuse training. Severity: 2 Scope: 2 Findings include: Employee #3 (E3) E3 was hired on 11/26/24 as a Caregiver. E3's file lacked documented evidence of initial elder abuse training in 2024. Employee #4 (E4) E4 was hired on 07/01/23 as a Caregiver. E4's employee file contained evidence of elder abuse training received on 06/28/23. E4's file lacked documented evidence of elder abuse training in 2024. On 03/18/25 in the afternoon, the Administrator acknowledged E3 did not complete initial Elder Abuse training and E4 did not complete annual Elder Abuse training. Severity: 2 Scope: 2			

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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 interview and record review, the facility failed to ensure 1) an initial two-step tuberculosis (TB) was completed upon hire and 2) a physical examination was completed upon hire for 2 of 10 sampled employees (Employee #9 and #10). Findings include: Employee #9 (E3) E9 was hired on 09/11/24, as a Caregiver. E9's file lacked documented evidence of a physical examination upon hire. Employee #10 (E10) E10 was hired on 06/26/24, as a Caregiver. E10's file lacked documented evidence of an initial two-step TB Test and a physical examination upon hire. On 03/18/25 in the afternoon, the Business Office Manager confirmed the employees did not complete the missing TB test and physical examinations. Severity: 2 Scope: 1	0102	**Tag 0102** – **E9** is no longer employed with us. **E9's** last day of work was **03/17/2025**. **E10** has not been working since **03/24/2025** and may return once we receive the results of her **TB test** and **physical**. **E10** went to get her TB QuantiFERON test on 04/02/2025, awaiting on result. **Physical** results received on **04/03/2025**. Moving forward, no employees will begin working on the floor unless the results are in the employees' folder, effective immediately.	04/07/2025

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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 record review and interview, the facility failed to ensure 2 of 10 sampled employees received initial cardiopulmonary resuscitation (CPR) and first aid training (Employee #4 and #10). Findings include: Employee #4 (E4) E4 was hired on 07/01/24, as a Caregiver. E4's file lacked documented evidence first aid and CPR training was completed. Employee #10 (E10) E10 was hired on 06/26/24, as a Caregiver. E10's file lacked documented evidence first aid and CPR training was completed. On 03/18/25 in the afternoon, the Business Office Manager confirmed the employees did not complete the missing first aid and CPR training. Severity: 2 Scope: 1	0106	**Tag 0106** – **E4** and **E10** arescheduled for a **CPR and First Aid** class on **April 8th and 9th,2025**. Moving forward, we will schedule monthly CPR and First Aidtraining in our community. No employees will begin working on the floor unlesswe have their CPR and First aid in the employees' folder, effectiveimmediately.	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 03/18/2025, 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 bottom portion of the deli preparation refrigerator, an open container of sour cream was expired on 02/26/25. 2. Major Violations: a. The following non-food contact surfaces were soiled with grease and/or food debris: the cook's line ventilation hood filters, underneath the griddle, sides of equipment on the cook's line, inside of the microwave and inside of reach-in units. b. The floor was soiled with food build-up and debris underneath tables and equipment throughout the kitchen. 3. Equipment and Maintenance Violations: a. The dipper well was not operating and in disrepair. Severity: 2 Scope: 3	0255	**Tag 0255**– The refrigerators in the Kitchen will be checked daily by culinary staff for expired items. If any item expires within24 hours, it will be disposed of. The staff member checking the refrigerators will initial the task complete daily and the monthly logs will be placed in a binder in the Kitchen. The Culinary Director or designee will be responsible to ensure that the staff is completing the task. The expired Sour Cream was discarded on 3/18/2025. **Kitchen Equipment –** Director of Culinary to ensure that cooks are cleaning equipment each day after use to avoid heavy grease build up and follow policy DIET 19- Sanitization (Please find attached policy) All Kitchen Equipment was deep cleaned on **4/2/2025.** **Kitchen Floors** – Director of Culinary to ensure that floors are being swept and mopped in between each meal period and ensure that table and equipment is being moved to ensure that there is no build up. Will follow **DIET 19- Sanitization policy** (Attached) All Kitchen floor were deep cleaned by 3/31/2025. The dipper well will be fixed on **4/5/2025** as parts have been ordered by the Maintenance Director.	04/07/2025

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 25 residents received an annual physical examination. (Resident #5, #22 and #23) Findings include: Resident #5 (R5) R5 was admitted on 09/13/21, with diagnoses including chronic obstructive pulmonary disease and memory impairment. R5's last documented physical examination was dated 02/01/24. R5's file lacked documented evidence of an annual physical examination. Resident #22 (R22) R22 was admitted on 06/19/23, with a diagnosis of chronic kidney disease. R22's last documented physical examination was dated 06/07/23. R22's file lacked documented evidence of an annual physical examination. Resident #23 (R23) R23 was admitted on 09/28/23, with diagnoses including coronary artery disease and hypotension. R23's last documented physical examination was dated 03/05/24. R23's file lacked documented evidence of an annual physical examination. On 03/18/25 in the morning, the Wellness Director acknowledged R5, R22 and R23's files lacked documented evidence of annual physical examinations and was unable to provide the missing documents. Severity: 2 Scope: 1	0859	**Resident Annual Physical Exam by an MD (PCP)**- Ensure residents have a physical exam on file for the previous calendar year. Missing documents will be obtained and filed immediately. We will implement a tracking log for annual physical, with scheduled reminders for residents and their families to ensure timely completion. Conduct quarterly file reviews to confirm compliance. The **Wellness Department** will maintain the records, send reminders, and collaborate with physicians to streamline documentation.	04/07/2025
0936 SS= E	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	0936	Residentshave an up-to-date TB test on file for 2024 (See attached documents). Movingforward, we will	04/07/2025

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	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 an initial two step tuberculosis (TB) test was completed for 1 of 25 residents (Resident #18) and an annual TB test was completed for 7 of 25 residents (Resident #1, Resident #2, Resident #9, Resident #12, Resident #13, Resident #16 and Resident #19). Findings include: Resident #1 (R1) R1 was admitted on 01/29/24 with diagnosis of Alzheimer's disease and cerebral vascular accident. Review of R1's medical record revealed R1 last completed a QuaniFERON test on 01/12/24. R1's medical record lacked documented evidence of an annual TB test. Resident #2 (R2) R2 was admitted on 04/10/24 with diagnosis including dementia. Review of R2's medical record revealed R2 last completed a TB test on 12/19/23. R2's medical record lacked documented evidence of an annual TB test. Resident #9 (R9) R9 was admitted on 03/04/22 with diagnosis including dementia. Review of R4's medical record revealed R4 last completed a TB test on 03/03/24. R9's medical record lacked documented evidence of an annual TB test. Resident #12 (R12) R12 was admitted on 02/02/23 with diagnosis including asthma and hypothyroidism. Review of R12's medical record revealed R2 last completed a TB test on 01/05/24. R12's medical record lacked documented evidence of an annual TB test. Resident #13 (R13) R13 was admitted on 03/17/23 with diagnosis including diabetes mellitus type 2 and prostate cancer. Review of R13's medical record revealed R13 last completed a TB test on 03/02/24. R13's medical record lacked documented evidence of an annual TB test. Resident		implement an annual TB testing schedule, ensuringresidents receive the test in advance of the due date. Regular audits will beconducted to verify compliance. The Wellness Department will track and scheduleresident TB tests, maintain accurate records, and coordinate with medicalproviders as needed.	

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	#16 (R16) R16 was admitted on 10/05/19 with diagnosis including dementia. Review of R16's medical record revealed R16 last completed a TB test on 10/06/23. R16's medical record lacked documented evidence of an annual TB test. Resident #18 (R18) R18 was admitted on 11/04/24 with diagnosis including diabetes mellitus type 2 and arthritis. Review of R18's medical record revealed R18 completed an initial TB test on 03/01/24. There was no documentation a two-step TB test was completed for R18. Resident #19 (R19) R19 was admitted on 12/14/23 with diagnosis including hypertension and glaucoma. Review of R19's medical record revealed R19 last completed a TB test on 10/16/23. R19's medical record lacked documented evidence of an annual TB test. On 03/18/25, in the morning, the Wellness Director confirmed a two-step TB test was not completed for R18 and annual TB screenings were not completed for R1, R2, R9, R12, R13, R16 and R19. Severity: 2 Scope: 2			

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure a door leading to the courtyard of the facility's memory care unit was equipped with a functional audible alarm. Findings include: On 03/18/25 in the morning, a tour of the facility revealed a door, located in the memory care unit, leading to a courtyard was equipped with a non-functioning alarm. When the door was opened no audible alarm sounded. On 03/18/25 in the morning, the Administrator acknowledged the door, located in the memory care unit, leading to a courtyard was equipped with a non-functioning alarm and when the door was opened no audible alarm sounded. The Administrator acknowledged doors leading to the outside of a memory care unit must have functional audible alarms. Severity: 2 Scope: 3	0991	MC Door leading to the MC courtyard door alarm was replaced at the time of survey. Maintenance will conduct weekly inspections of door alarms and staff will notify maintenance immediately should door alarms malfunction.	04/07/2025
1540 SS= D	Cultural Competency Training - R004-24 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or	1540	All new and existing employees (**E3, E8, and E10**) have been scheduled for **Cultural Competency Training** on **April 18th, 2025**. Moving forward, the Administrative Assistant will ensure that new employees will be scheduled for Cultural Competency Training during the onboarding process.	04/07/2025

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	9018	A. BUILDING _____ B. WING _____	03/18/2025

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	employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 10 sampled employees received cultural competency training completed within 90 days of hire (Employee #3, #8, #9, and #10). Findings include: The following employee files lacked documented evidence cultural competency training was completed within 90 days of hire. Employee			

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	#3 was hired on 11/26/24, as Caregiver. Employee #8 was hired on 09/09/24, as the Wellness Director. Employee #9 was hired on 09/11/24, as a Caregiver. Employee #10 was hired on 06/26/24, as a Caregiver. On 03/18/25 in the afternoon, the Business Office Manager acknowledged the employee files lacked documented evidence of cultural competency training and was unable to provide the training. This was a repeat deficiency from the 03/05/24 State Licensure survey. Severity: 2 Scope: 2			
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current	1600	New resident Face sheet has been updated for pronouns. Thiswas implemented on 3/19/2025.	04/07/2025

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	anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility lacked updated policies and procedures addressing the residents preferred pronoun, gender expression and sexual orientation for 25 of 25 residents. Findings include: A review of the resident records revealed the facility lacked updated forms which included a process and procedure to document the resident's gender identification or expression in their medical/resident/patient records. There were 25 residents files that did not include documentation of preferred pronoun, gender expression and sexual orientation. On 03/18/25 in the morning, the Administrator confirmed there was no documentation of preferred pronoun, gender expression and sexual orientation and had not added this information to their admission documents for all residents who resided at the facility. Severity: 1 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to	1700	We will verify that residents have a completed annual assessment and placement document on file. Missing or outdated records will be updated immediately. Moving forward, we will establish an assessment schedule to ensure residents are evaluated annually. The Wellness Department will conduct periodic file checks to confirm documentation is complete. The **Wellness Department** will coordinate assessments, maintain records, and communicate with families and staff to ensure timely placement updates.	04/07/2025

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	determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to ensure an annual placement assessment was conducted by a physician for 1 of 25 sampled residents (Resident #12). Findings include: Resident #12 (R12) R12 was admitted to the facility on 02/23/23 with diagnoses including hypothyroidism, asthma, allergies, and osteoporosis. A physician placement assessment dated 02/09/23 in R12's file documented R12 was appropriately placed in a residential assisted living facility and was the last placement assessment conducted by the physician. Resident Service Plan dated 05/18/23 documented: Behavioral-Cognitive; Mood Behavioral Symptoms: Presence of Mood Behavioral Symptoms:			

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	Caregivers will proactively monitor the resident's symptoms to ensure the resident remains safe and is not expressing the desire to hurt self or others. Caregivers will report related concerns or changes immediately and intervene as needed. May need support and redirecting secondary to the following: Depression, Anxiety. Resident Service Plan dated 07/12/23 documented: Hallucinations/Delusions/Paranoia. Mood and Behavior Care Comments: R12 has an episode of anxiety looking for family and saying R12's lonely. Knocks on resident's door at night looking for family. Resident Service Plans dated 03/10/24, 06/12/24 and 08/29/24 documented: Resident was found sleeping in another resident's room, also fixated on room temperature and calls multiple times about it. Resident Service Plans for 06/12/24 and 08/29/24 included an entry for Safety: Check on Resident 4-6 times per day to ensure their safety. Offer assistance as needed. A handwritten Physician Notification in R12's file completed by an employee dated 10/07/24 documented Resident 12 is disturbing another resident. Every night R12 is knocking on some of the doors even at night, for 3 weeks R12 was doing it. R12 asking the resident for a companion and to sleep with R12. Under Physician's Response on the notification form, the provider documented, no action needed. Continue with current plan of care, Will follow up with patient. The provider signed and dated the notification on 10/10/24. A handwritten Physician Notification in R12's file completed by an employee dated 10/17/24 documented Resident was agitated/anxious and knocked on 112 apartment and went inside, R12 refused to go out of the apartment. However, staff got R12 out and R12 ran out the back door and out to the parking garage, seen by employees. Under Physician's Response on the notification form, the provider wrote Will see today 10/19/24. The provider signed and dated the notification on 10/19/24. R12's file lacked a current placement assessment by R12's physician. In an interview on 03/18/25 in the afternoon, E11 indicated the Medication Technicians and Caregivers asked R12 to calm down when			

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	they found R12 knocking on other residents' doors, and would take R12 back to R12's room. Per a staff member, staff went back every 15 minutes to half an hour to sit with R12 for five minutes. The staff charted the incidents and reported the incidents to the Wellness Director and to R12's family member. Two staff members verbalized R12 wandered at night. On 03/18/25 in the afternoon, the Administrator acknowledged a current physician placement assessment was not in R12' file. Severity: 2 Scope: 1			