STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9216	A. BUILDING _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MONTECITO MEMORY CARE	6660 GRAND MONTECITO PARKWAY, LAS VEGAS, NEVADA ,89149

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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 04/16/25, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for 46 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's Disease and/or Assisted Living Services, Category II residents. The census at the time of the survey was 33. Ten 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		
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 04/16/2025, 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 walk-in cooler, a large pot of beef soup was prepared on 04/15/25. The temperature of the beef soup was measured to be between 48 degrees Fahrenheit (F) to 50 degrees F, which was in the temperature danger zone indicating the beef soup was not cooled down properly. b. In the walk-in cooler, raw Italian sausage was stored on the top rack of a shelving unit above cooked foods such as pasta and soup, and above produce such as cauliflower and broccoli. c. A certified food protection manager was not	0255	On 05/02/25 the kitchen ventilation hood, range, grill, griddle, top and underside of the charbroiler, outside of the drawer refrigerator, reach in units, reach in freezer, deli fridge, microwave, lower shelves of tables, floors, ice machine, and ceiling tiles were deep cleaned. On 05/07/25 an in-service was held with the kitchen staff to review the assigned kitchen duties, cleaning schedule, and maintenance of the kitchen appliances. Another In-service was held on 05/22/25 with the kitchen staff to review food labeling, proper food temperatures, proper food storage, labeling, reports, logs, and again the assigned cleaning duties. On 05/21/25 another cook was registered for a Serv Safe course so we can ensure one Serv Safe cook is onsite during each shift. All staff will be in-serviced by the end of the month at our next allstaff about entering the kitchen without a proper food handlers card, helping themselves to food items with bare hands, eating in the kitchen, and serving food without hair nets. The Executive Director and/or Executive Chef will monitor for compliance.	05/22/2025

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	onsite to ensure food safety practices were followed in the kitchen and during food service operations. d. A caregiving staff member was observed to enter the kitchen, obtained a cooked sausage link and proceeded to eat the sausage link with bare hands in the kitchen. 2. Major Violations: a. At the start of the kitchen inspection, a medication technician was observed in the kitchen scooping ice cream from a large container and did not have their hair restrained by an effective means. b. The interior plastic shield of the ice machine had heavy pink biofilm and grime build-up. c. The following non-food contact surfaces of equipment were soiled with grease, debris and/or spillage: the cook's line ventilation hood; the sides of the range, grill and griddle; the top and underside of the salamander broiler; the flue of the griddle; the outside of the drawer refrigerators and reach-in units; the inside of the reach-in freezer, refrigerator and deli preparation refrigerator; the outside and inside of the microwave; and the lower shelves of tables. d. The floor was heavily soiled with food and debris under the beverage table and tray line equipment. e. There was dust build-up on the ceiling tiles above the tray line and in the dish wash area. Severity: 2 Scope: 3			

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0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on interview and record review, the facility failed to ensure a Person Centered Care plan was developed for 1 of 10 residents (Resident #10). Findings include: Resident #10 (R10) R10 was admitted on 03/31/25 with diagnoses including dementia, hallucinations, type II diabetes and chronic encephalopathy. R10's file was reviewed and revealed R10's file lacked documented evidence of a Person Centered Care Plan. On 04/16/25 in the afternoon, the Wellness Director confirmed R10's Person Centered Care plan was not completed and not signed off by the facility or the resident/resident designee. Severity: 2 Scope: 1	0515	A person centered care plan was created for resident#10 on 05/07/25. The Administrator retrained the Executive Director and Health Services Directors about the person centered care plans and regulations. A Resident tickler for tracking purposes has been created to help for tracking. All resident files will be audited by 05/31/25. Going forward the Health Services Director and/or Executive Director will ensure that all residents have an initial and annual person centered care plan in their file.	05/12/2025

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on interview and record review, the facility failed to obtain a medical exemption to maintain one resident who received wound care (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 03/14/25 with diagnoses including an unspecified injury of the head and a cognitive deficit. A Skilled Nursing Visit Note dated 04/14/25 documented R1 received wound care for Wound #1 an unstageable pressure ulcer wound to coccyx, Wound #2 a deep tissue injury to left heel, Wound #3 deep tissue injury to right heel, Wound #4 a skin tear to the middle of R1's back, Wound #5 a skin tear to R1's right knee, and Wound #6 a skin tear to R1's right elbow. A Hospice Interdisciplinary Group Meeting dated 04/16/25 documented the goal for R1 was for R1's wounds to resolve. R10's file lacked documented evidence of an approved medical exemption for receiving wound care from the Bureau. On 04/16/25 in the afternoon, the Memory Care Director acknowledged R1 did not currently have an approved medical exemption on file for having wounds. Severity: 2 Scope: 1	0620	Resident #1 passed away on 04/23/20225. The Administrator retrained the Memory Care Director and Executive Director on Medical Exemptions on 05/12/2025. All Resident files have been reviewed for any medical exemptions. Going forward the Administrator and/or Designee will ensure that all medical exemptions request are completed and in the resident file.	05/12/2025
0859 SS= F	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	0859	On 04/27/25 resident#1 passed away. On 05/13/25 resident#2'sphysical was completed. On 04/26/25 resident#3's physical was completed.On 06 /11 /24 resident#4's physical was completed, and on 05/17/25 anew physical request was sent to resident#4's primary. On 05/20/25 resident#5'sphysical was completed. On 04/22/25 resident#6's physical was completed. On04/22/25 resident#6's physical was completed. On 04/22/25 resident#9's physicalwas completed. On	05/23/2025

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	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 residents received an initial (Resident #1) and annual physical examination. (Resident #2, #3, #4, #5, #6, #9 and #10) Findings include: Resident #1 (R1) R1 was admitted on 03/14/25, with diagnoses including an unspecified injury of the head and cognitive deficit. R1's file lacked documented evidence of an initial physical examination. Resident #2 (R2) R2 was admitted on 03/07/23 with a diagnosis of dementia. R2's last documented physical examination was dated 02/01/24. R2's file lacked documented evidence of an annual physical examination. Resident #3 (R3) R3 was admitted on 07/28/21 with a diagnosis of dementia. R3's last documented physical examination was dated 12/11/23. R3's file lacked documented evidence of an annual physical examination. Resident #4 (R4) R4 was admitted on 11/25/23, with a diagnosis of dementia. R4's last documented physical examination was dated 10/17/23. R4's file lacked documented evidence of an annual physical examination. Resident #5 (R5) R5 was admitted on 10/05/20 with a diagnosis of dementia. R5's last documented physical examination was dated 02/19/24. R5's file lacked documented evidence of an annual physical examination. Resident #6 (R6) R6 was admitted on 06/07/22 with a diagnoses including dementia, asthma and bronchitis. R6's last documented physical examination was dated 02/27/24. R6's file lacked documented evidence of an annual physical examination. Resident #9 (R9) R9 was admitted on 08/05/21, with a diagnosis of dementia. R9's last documented physical examination was dated 02/01/24. R9's file lacked documented evidence of an annual physical examination. Resident #10 (R10) R10 was admitted on 03/31/25 with diagnoses including dementia, hallucinations, type II diabetes and chronic encephalopathy. R10's file lacked documented evidence of an initial physical examination. On 04/16/25, in the afternoon the Memory Care Director acknowledged		03/28/25 resident#10's physical was completed. The Administratorretrained the Executive Director and Health Services Director on the regulationsregarding initial and annual physicals for all residents on 05/12/25. A resident ticklerwas created for the Health Services Director to track when physicals will bedue. The Administrator and/or Designee will monitor for compliance bycompleting quarterly file audits.	

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	R1, R2, R3, R4, R5, R6, R9 and R10's files lacked documented evidence of the required initial and/or annual resident physicals. Severity: 2 Scope: 3			
0874 SS= F	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the facility failed to ensure the Administrator reviewed and initialed six-month medication reviews for 9 of 10 sampled residents, per the requirement. (Resident #2, #3, #4, #5, #6, #7, #8, #9 and #10) Findings include: Resident #2 (R2) R2 was admitted on 03/07/23 with a diagnosis of dementia. R2's 09/10/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #3 (R3) R3 was admitted on 07/28/21 with a diagnosis of dementia. R3's 09/10/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #4 (R4) R4 was admitted on 11/25/23 with a diagnosis of dementia. R4's 09/20/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #5 (R5) R5 was admitted on 10/05/20 with diagnoses including dementia and chronic obstructive pulmonary disease (COPD). R5's 09/10/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #6 (R6) R6 was admitted on 06/27/22 with diagnoses including dementia, asthma and bronchitis. R6's 09/10/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials.	0874	Medication reviews were completed for Resident #2, #3, #4, #5, #6, #7, #8, and #9 on June 2024, September 2024, December 2024, and March 2025. All medication reviews were reviewed and signed by the Administrator on 05/12/25. On 05/22/25 the Administrator reviewed and signed resident#10's medication records with the multiple orders with different dosages. The Administrator retrained the Executive Director and Health Services Director on the regulations regarding medication reviews. A resident tickler was created to help track when medication reviews were last completed and due next. The Administrator and/or Designee will monitor ongoing for compliance by doing periodic audit files.	05/22/2025

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	Resident #7 (R7) R7 was admitted on 07/18/23 with diagnoses including dementia, hypertension, and osteoporosis. R7's 09/10/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #8 (R8) R8 was admitted on 05/15/23 with diagnoses including dementia, hypertension, and major stroke. R8's 09/10/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. Resident #9 (R9) R9 was admitted on 08/05/21 with a diagnosis of dementia. R9's 09/20/24 and 03/31/25 Medication Reviews lacked documented evidence of the Administrator's review and initials. On 04/16/25 in the afternoon, the Memory Care Director acknowledged the missing Administrator initials on the 09/20/24 and 03/31/25 Medication Reviews for R2, R3, R4, R5, R6, R7, R8, and R9. Resident #10 (R10) R10 was admitted on 03/31/25 and documented with diagnoses including dementia, hallucinations, type II diabetes and chronic encephalopathy. R10's prescriptions were reviewed by the Wellness Director/Memory Care Director who indicated the facility had been contacting the physician via facsimile since 04/01/25 to update the order for Sodium Chloride. The MAR and medical records received from the discharging facility had multiple entries with different dosages for the administration of the resident's prescribed Sodium Chloride. These were recognized as concerns by the Wellness Director/Memory Care Director. The entries of concern lacked documented evidence of the Administrator's review and initials within the required 72 hours after the concerns were noted by the person who submitted the report to notify the resident's physician of the multiple orders with different dosages. Severity: 2 Scope: 3			
0878 SS= E	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	0878	On 04/23/25 we received resident#4's Memantine, and on 04/29/25we received resident#4's Amlodipine. On 02/19/25 we received a DC order for theCerave lotion, and on 05/20/25 we received a DC order for the Medi Pads forresident#5. On 04/17/25	05/22/2025

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	resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and interview, the facility failed to		we received the Miconazole 2%powder. On 05/08/25 we received Resident#7's Alendronate sodiummedication. On 04/22/25 we received a new med order for the Sodium Chloride 1GMtab by mouth 2 times daily, and on 05/22/25 we received the DC order for resident#10'sSodium Chloride 1GM tab by mouth 3 times daily. On 05/22/25 The Administratorand Regional Nurse retrained the Executive Director, Health Services Director,and Medtechs with a Medication Administration Refresher. We reviewed the importanceof documentation and timely refills, and the proper procedures to contact aphysician when a medication is missed, out of refills, or needs clarification. TheExecutive Director and/or Health Services Director will monitor for complianceby doing periodic medication cart audits, and twice a year the contracted pharmacywill complete medication cart audits.	

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	ensure medications were on site and available for administration, administered per physician's orders and a medication order was clarified. (Resident #3, #4, #5, #7 and #10) Findings include: Resident #4 (R4) R4 was admitted on 11/25/23, with a diagnosis of dementia. R4's physician order dated 12/22/23 and the April 2025 Medication Administration Record (MAR) documented Amlodipine 10 mg (milligrams), take one tablet by mouth every day. There was no documented evidence on the MAR the Amlodipine was administered on 04/10/25 and 04/11/25. R4's physician order dated 07/26/24 and the April 2025 Medication Administration Record (MAR) documented Memantine HCl 10 mg, take one tablet two times daily. There was no documented evidence on the MAR the Memantine was administered on 04/14/25 at 8:00 AM. On 04/17/25 at 11:48 AM, the Medication Technician (Med Tech) acknowledged R4's medications were not administered per the physician's orders because the medications had not been received by the pharmacy on those dates. Resident #5 (R5) R5 was admitted on 10/05/20 with diagnoses including dementia and chronic obstructive pulmonary disease (COPD). A physician order dated 04/10/25 documented Miconazole 2% powder daily at 8:00 AM/ 1 Powd; 5:00 PM /1 Powd; apply topically two times daily to affected area of groin, abdominal folds, and under breasts. On 04/16/25 in the afternoon, there was no Miconazole 2% powder on site for R5. In an interview on 04/16/25 in the afternoon, the medication technician Employee #8 (E8) acknowledged Miconazole 2% powder was not onsite and available for R5. R5's April 2025 MAR documented Cerave Lotion, apply a thin layer to the affected area every day as needed for itching; "may keep in room." A physician order dated 09/06/23 documented Cerave Lotion, apply a thin layer to affected area every day as needed for itching; *may keep in room.* On 04/16/25 at 3: 34 PM, E8 confirmed there was no Cerave Lotion available to administer for R5 in the medication room. R5's April 2025 MAR documented Medi Pads Med. Pad, apply external pads topically to rectal area up to six times daily			

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	as needed for hemorrhoids (after each bowel movement). A physician order dated 09/06/23 documented Medi Pads Med., apply external pads topically to rectal area up to six times daily as needed for hemorrhoids (after each bowel movement). On 04/16/25 in the afternoon, medicated pads were not on site and available to provide for R5. Resident #7 (R7) R7 was admitted on 07/18/23 with diagnoses including dementia, hypertension, and osteoporosis. R7's April 2025 Medication Administration Record (MAR) documented Alendronate Sodium 70 milligrams (mg) tablet, one tablet by mouth weekly with 6-8 ounces (oz) of water; thirty minutes before food or medications; remain upright for thirty minutes. The MAR indicated the medication had been administered to R7 on 04/03/25 and 04/10/25 at 7:00 AM. A physician order dated 11/22/23 documented Alendronate Sodium 70 milligrams (mg) tablet, one tablet by mouth weekly with 6-8 ounces (oz) of water; thirty minutes before food or medications; remain upright for thirty minutes. On 04/16/25 at 1:23 PM, Alendronate Sodium 70 mg tablets were not on site for R7. In an interview on 04/16/25 at 1:23 PM, medication technician Employee #9 (E9) acknowledged the Alendronate Sodium was not onsite. By the following day (04/17/25), the facility did not provide documented evidence that Alendronate Sodium was delivered from the pharmacy and available to be administered to R7 per the physician order. Resident #10 (R10) R10 was admitted on 03/31/25 with diagnoses including dementia, hallucinations, type II diabetes and chronic encephalopathy. On 04/16/25 at 2:35 PM, R10's April 2025 Medication Administration Record (MAR) documented the following: Prescription Issue Date: 04/01/2025, Sodium Chloride 1GM Tab, Take 1 tab by mouth 2 times daily On 04/16/2025 in the afternoon, a bubble pack containing Sodium Chloride 1GM Tablets included a pharmacy label with instructions to Take 1 tab by mouth 2 times daily. The MT verbalized without a physician's order their practice was to administer the Sodium Chloride as instructed on the pharmacy label on the bubble pack. The April 2025 MAR revealed			

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	9216	A. BUILDING _____ B. WING _____	04/16/2025

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	on 04/07/25 at noon, R10 was administered 2 tablets (2 grams) by mouth and not as instructed on the pharmacy label on the bubble pack. On 04/16/25 in the afternoon, the Wellness Director verified the facility had not contacted the physician to clarify the correct dosage for R10's Sodium Chloride. Severity: 2 Scope: 3			
0883 SS= D	Medication - Resident Refusal - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 7. If a resident refuses, or otherwise misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident's record had documented evidence a physician was notified after a resident had missed medications for 1 of 10 sampled residents (Resident #4). Resident #4 (R4) R4 was admitted to the facility on 11/25/23, with a diagnosis of dementia. A Physician's Order dated 07/26/24, and the April 2025 Medication Administration Record (MAR) documented Memantine HCl 10 mg, take one tablet two times daily. There was no documented evidence on the MAR the Memantine was administered on 04/14/25 at 8:00 AM. There was no documented evidence the physician was notified after the missed dose of medication on 04/14/25. On 04/16/25 in the morning, the Medication Technician (Med Tech) acknowledged R4's Memantine HCl 10 mg was not administered per the physician's order because it was not onsite to be administered at 8:00 AM on 04/14/25. The Med Tech confirmed the facility had no documented evidence R4's physician was notified after the missed dose. Facility Medication Availability Policy dated 06/20/24 documented if at any time a medication is not available.....this should be noted in the Electronic Medication Record (EMAR) with physician notification requesting instructions and/or guidance on how to proceed. Severity: 2 Scope: 1	0883	On 04/23/25 resident #4's Memantine HCL 10mg was filled and delivered. The Administrator and Regional Nurse retrained the medtechs on the policies and procedures for missed medication, notifying the physician, and proper documentation. The Administrator and or Designee will monitor for compliance by completing periodic medication cart audits.	05/22/2025

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 sampled residents were tested for tuberculosis (TB) prior to being admitted to the facility (Residents #2 and #7). Findings include: Resident #3 (R3) R3 was admitted on 07/28/21 with a diagnosis of dementia. R3's resident file lacked documented evidence of a two-step Mantoux tuberculin skin test or a Quantiferon blood test within 24 hours of R3 being admitted to the facility. R3's file lacked documented evidence of a completed TB test since being admitted. Resident #8 (R8) R8 was admitted on 05/15/23 with diagnoses including dementia, hypertension, and major stroke. R8's resident file documented a one-Step Mantoux TB test conducted on 01/19/23. R8's lacked documented evidence of a second step TB skin test or a Quantiferon blood test prior to being admitted to the facility. R8's file lacked documented evidence of another completed TB test since being admitted. On 04/16/25 in the afternoon, the Memory Care Director acknowledged R3 and R8 did not have evidence of TB testing within 24 hours of admittance to the facility, nor additional documented completed TB testing since being admitted. Severity: 2 Scope: 1	0936	On 05/15/25 a second step tb was completed for resident #3, and on 05/02/25 a second step was completed for resident #8. The Administrator retrained the Executive Director and Memory Care Director on 05/12/25 on TB's and regulations. A resident tickler was created to help track the residents initial and annual tb tests. Going forward the Memory Care Director and/or Executive Director will ensure all residents have an initial and annual tb test by completing file audits quarterly.	05/12/2025
0938 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident;	0938	On 04/08/25 an assessment was completed for resident #2, on 05/06/25 an assessment was completed for resident #3, on 04/08/25	05/12/2025

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	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 (Resident #1) and annual Activities of Daily Living (ADL) Assessment (Resident #2, #3, #4, #5, #7, #8, #9 and #10) was completed for 9 of 10 sampled residents. Findings include: Resident #1 (R1) R1 was admitted on 03/14/25 with diagnoses including an unspecified injury of the head and a cognitive deficit. R1's file lacked documented evidence of an initial ADL Assessment. Resident #2 (R2) R2 was admitted on 03/07/23 with a diagnosis of dementia. R2's file documented an ADL Assessment last completed on 11/25/23. R2's file lacked documented evidence of an annual ADL assessment. Resident #3 (R3) R3 was admitted on 07/28/21 with a diagnosis of dementia. R3's file documented an ADL Assessment last completed on 09/26/23. R3's file lacked documented evidence of an annual ADL assessment. Resident #4 (R4) R4 was admitted on 11/25/23 with a diagnosis of dementia. R4's file documented an ADL Assessment last completed on 01/23/24. R4's file lacked documented evidence of an annual ADL Assessment. Resident #5 (R5) R5 was admitted on 10/05/20 with diagnoses		an assessment was completed for resident #4, on 01/22/25 an assessment was completed for resident #5, on 12/01/24 an assessment was completed for resident #7, on 05/09/25 an assessment was completed for resident #8, on 12/01/24 an assessment was completed for resident #9, on 04/13/25 an assessment was completed for resident #10. The Administrator retrained the Executive Director and Health Services Director on Initial and Annual Assessments and state regulations on 05/12/25. A resident tickler was created to help track resident items and due dates. All resident files will be audited by 05/31/25. Going forward the Executive Director and/or Health Services Director will ensure assessments are completed for each resident initially and annually by doing quarterly file audits.	

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	including dementia and chronic obstructive pulmonary disease (COPD). R5's file documented an ADL Assessment last completed on 10/26/23. R5's file lacked documented evidence of an annual ADL assessment. Resident #7 (R7) R7 was admitted on 07/18/23 with diagnoses including dementia, hypertension, and osteoporosis. R7's file documented an ADL Assessment last completed on 10/26/23. R7's file lacked documented evidence of an annual ADL assessment. Resident #8 (R8) R8 was admitted on 05/15/23 with diagnoses including dementia, hypertension, and major stroke. R8's file documented an ADL Assessment last completed on 12/22/23. R8's file lacked documented evidence of an annual ADL assessment. Resident #9 (R9) R9 was admitted on 08/05/21 with a diagnosis of dementia. R9's file documented an ADL Assessment last completed on 10/29/23. R9's file lacked documented evidence of an annual ADL Assessment. Resident #10 (R10) R10 was admitted on 03/31/25 with diagnoses including dementia, hallucinations, type II diabetes and chronic encephalopathy. R10's file was reviewed and revealed R10's file lacked documented evidence of an initial ADL Assessment. On 04/16/25 in the afternoon, the Memory Care Director acknowledged the facility lacked documented evidence of a completed initial ADL Assessment for R1 and R10 and annual ADL Assessments for R2, R3, R4, R5, R7, R8 and R9. Severity: 2 Scope: 3			

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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, interview and document review, the facility failed to ensure all doors leading to the exterior of the building were equipped with audible alarms that activated when the doors were opened. Findings include: On 04/16/25 in the morning, the doors leading to the courtyard were tested to observe what type of alarm the facility had installed. When the doors were opened, there were no audible alarms to alert facility staff when any of the courtyard doors were opened. The Environmental Services Director (ESD) indicated the doors leading to the courtyard did not have an audible alarm system since his employment with the facility. On 04/16/25 in the morning, the ESD acknowledged there were no audible alarms to alert facility staff when any of the courtyard doors were opened. Severity: 2 Scope: 3	0991	On 04/16/25 the batteries were replaced in the audible door alarm, and tested in working condition. The Administrator retrained the Executive Director and Maintenance Director on 05/13/25 regarding the door alarms and regulations. All staff will be retrained by 05/31/25. Going forward the Maintenance Director and/or Executive Director will check the doors periodically as part of their routine walks of the property to ensure the door alarm is working.	05/13/2025

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0999 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: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure toxic substances were not accessible to the residents in the memory care unit. Findings: On 04/16/25 in the morning, observed unsecured in the cabinets under the sinks in the dining area and creative engagement room were the following: a container of hand sanitizer cleaning solvents and, activity paint supplies On 04/16/25 in the morning, the Environmental Services Director (ESD) acknowledged the toxic substances were unsecured. Severity: 2 Scope: 3	0999	On 04/16/25 the hand sanitizer, cleaning solvents, and activity paint supplies were removed from the cabinet underneath the kitchen sink and relocated to secure cabinets out of resident accessibility. On 05/13/25 the Maintenance Director installed new child proof locks on the cabinets under the sink in the dining area and creative engagement room. The Administrator retrained the Executive Director and Maintenance Director on 05/13/25 regarding toxic substances and resident accessibility and the regulation. All staff will be retrained by 05/31/25. The Executive Director and/or Designee with ensure compliance by periodically checking the cabinets under the sinks and in the creative engagement room to ensure that cabinets are secured, and no toxic chemicals or substances are accessible to residents.	05/13/2025