DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**06/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA COURT ASSISTED LIVING	**3985 SOUTH PEARL STREET, LAS VEGAS, NEVADA ,89121-7205**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an Annual State Licensure survey, complaint and Facility Incident Report investigation conducted at your facility on 06/04/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for 69 Residential Facility for Group beds for elderly and disabled persons and/or persons with Mental Illness, and Assisted Living services, Category II residents. The census at the time of the survey was 61. Fifteen resident files and eight employee files were reviewed. The facility received a grade of C. There were six complaints and one Facility Reported Incident (FRI) investigated. Substantiated: 1. Complaint #NV00073753 was substantiated. (See Tag Y0170). 2. Complaint #NV00074348 was substantiated. (See Tag Y0178). 3. Complaint #NV00074279 was substantiated. (See Tags Y0050, Y0515 and Y0853) 4. FRI #11395 was substantiated. (See Tags Y0050, Y0515 and Y0853) Substantiated Without Deficient Practice: 5. Complaint #NV00073743 was substantiated without deficient practice. No regulatory deficiencies could be identified. Unsubstantiated: 6. Complaint #NV00074132 could not be substantiated. No regulatory deficiencies could be identified. 7. Complaint #NV00073289 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaints and FRIs included: Observations of staff/resident interactions, appropriate resident hygiene, facility water temperatures, laundry storage, housekeeping in resident rooms, residents' bathrooms, residents receiving medications and call light response times. Interviews were conducted with residents, the maintenance director, the Executive Director, caregivers, medication	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARCUS PEGROSS Title: Executive Director Date: 08/20/2025

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	technicians, housekeeping, the Wellness Director and a Wellness Coordinator, and Hospice provider. Clinical Record Review of 16 records, which included the residents of concern. Document Review included facility policy and procedures, grievance logs, water temperature logs, Activities of Daily Living (ADL) logs, shower schedules, hospice records and staffing schedule. 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 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:			
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 record review and interview, the facility failed to ensure a person-centered service plan documented a residents behavior issue of starting fires and that the facility would keep possession of a resident's cigarettes and lighter 1 of 19 residents (Resident #19). Findings include: Resident #19 (R19) R19 was admitted to the facility on 01/30/23, with diagnoses including bipolar disorder and depression. R19's file lacked a person-centered service plan which documented R19's cigarettes and lighter would be kept in possession of the facility and R19's behavior or lighting items on fire. On 09/08/24 at 7:05 PM, a text message from	0515	*Date of correction* •□□□□□□08/30/2025 *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* •□□□□□□R19 who was directly affected by the deficient practice is no longer residing at the community. *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□□□□□□Community is currently conducting an audit, with an anticipated completion date of 8/30/25, of all resident files to review plans of care to ensure any reported behaviors that place the resident or others in imminent risk of harm to their health and/or safety is addressed in the resident's plan of care. •□□□□□□The Wellness Director and/or designee will conduct a check of the	08/20/2025

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	the Wellness Director to R19's family member documented the facility took R19's lighter because R19 had lit their mail on fire. According to the Wellness Director, the facility would keep R19's cigarettes and lighters in the medication room where R19 could come and ask for them. The Wellness Director documented the facility would then go out and light the cigarette for R19. On 06/04/25 at 9:06 AM, Resident #17 (R17) verbalized a Medication Technician told them to not give R19 a lighter because R19 was burning other things. R17 knew not to give R19 cigarettes or a lighter. On 06/04/25 at 9:08 AM, Resident #5 (R5) reported R19 had previously set fire to R19's mail sometime in August 2024. According to R5, the Administration told them not to give R19 cigarettes or a lighter. On 06/04/25 at 9:10 AM, Resident #15 (R15) verbalized it was widely known R19 could not have lighters and R19 was always asking R15 for a light and cigarettes. On 06/04/25 at 9:19 AM , Resident #18 (R18) reported being told by staff to not give R19 a lighter and stated R19 had an incident previously in their room with fire where staff had to intervene. On 06/04/25 at 9:27 AM, the Wellness Coordinator verbalized residents were told not to give R19 cigarettes and lighters after R19 attempted to set their mail on fire in their room sometime in August of 2024. On 06/04/25 at 9:38 AM, a Medication Technician verbalized R19 was not allowed to have a lighter and staff would light R19's cigarettes for R19. On 06/04/25 at 9:41 AM, a Medication Technician reported R19 came to the Medication Technicians for R19's cigarettes and lighter. According to the Medication Technician, all residents knew not to give R19 a cigarette or lighter. On 06/04/25 at 10:45 AM, the Administrator acknowledged R19's care plan did not document that the facility was to possess R19's cigarettes and lighter or that R19 had an issue with starting fires. On 06/26/25 at 11:11 AM, R19's family member verbalized R19 had passed away due to burns they		plans of care for any residents newly admitted or residents that have had a noted change in condition in the week prior to ensure that it is person centered and include any changes in behaviors that have been reported. *How will the corrective action be monitored to ensure the deficient practice Will not reoccur.* •□□□□□□Executive Director and/or designee will conduct bi-weekly checks of new admission service plans for the next 60days and if substantial compliance is observed periodically thereafter.	

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	received while lighting a cigarette at the facility on 04/13/25. According to R19's family member, the Wellness Director documented on 09/08/24 via text message that the facility would keep R19's cigarettes and lighter in the medication room after R19 had lit their mail on fire. The Wellness Director reported facility staff would escort R19 outside and light R19's cigarette for them. Severity: 2 Scope: 1 Complaint # NV00074279			
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 observation, interview and record review, the facility failed to obtain a waiver to maintain a resident who was bedfast, for 1 of 15 residents (Resident #8). Findings include: Resident #8 R8 was admitted on 03/29/25 with diagnosis including edema. On 06/04/25, in the morning, R8 was found laying in bed and revealed they could not turn from side to side without staff assistance. On 06/04/25, in the morning, a caregiver confirmed R8 could not turn in bed without staff assistance. Review of R8's medical record lacked documentation a bedfast waiver was obtained. On 06/04/25, in the morning, the Wellness Director confirmed they had no obtained a bedfast waiver for R8. Severity: 2 Scope: 1	0620	*Date of correction* •□□□□□□DATE OBTAINED PROVISIONALWAIVER FOR R8 8/15/25 *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* •□□□□□□Bed fast waiver has been initiated for R8. Community is currently awaiting final, but community was granted a provisional waiver. *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□ □ □ □Χομμυνιτψ χονδυχτεδ *a review of residents to determine if any other residents need bed waiver and those waiver request have been requested as of 8/19/25.* •□□□□□□The Wellness Director and/or designee will be responsible to apply for a waiver from the state if the community wishes to admit or retain a bed fast resident. Bed fast residents will not be admitted until a waiver is obtained, and the date of the waiver application and granting of any provisional waiver will be documented	08/20/2025

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			in any current resident's record. *How will the corrective action be monitored to ensure the deficient practice Will not reoccur:* •□□□□□□Executive Director and/or designee will conduct bi-weekly checks of new admission service plans for the next 60days and if substantial compliance is observed at least 1x month for 60 days.	
0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report was completed for 1 of 15 sampled residents (Resident #19). Findings include: Resident #19 (R19) R19 was admitted to the facility on 01/30/23, with diagnoses including bipolar disorder and depression. On 09/08/24 at 7:05 PM, a text message from the Wellness Director to	0853	*Date of correction* •□□□□□□08/25/2025 *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□□□□□□Re-education was conducted for all wellness staff regarding incident reports by wellness director and ED on8/10/25. Staff were re-educated on reporting all incidents to supervisor and that incident report should be initiated on day of incident. •□□□□□□The Wellness Director/designee will conduct at least a weekly check to ensure incident reports are completed for any incidents reported that week. *How will the corrective action be monitored to ensure the deficient practice Will not reoccur:* •□□□□□□The Executive Director and/or	08/20/2025

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	R19's family member documented the facility took R19's lighter because R19 had lit thier mail on fire. The Wellness Director explained, the facility would keep R19's cigarettes and lighters in the medication room where R19 could come and ask for them when needed. The Wellness Director documented the facility would then go out and light the cigarette for R19. On 06/04/25 at 10:45 AM, the Administrator verbalized hearing about R19 allegedly lighting an envelope on fire previously, and acknowledged the facility had not completed an incident report. According to the Administrator, the facility was not sure the incident happened. On 06/04/25 at 11:00 AM, the Wellness Director verbalized hearing about an incident R19 had where R19 lit their mail on fire. The Wellness Director was not sure if the facility had completed an incident report regarding the incident, but the Wellness Director acknowledged notifying R19's family member about the incident when it occurred. On 06/05/25 at 2:20 PM. a Caregiver reported R19 had lit their mail on fire while they were working. According to the Caregiver, they ran over to R19 and put the fire out. The Caregiver verbalized that they did not do an incident report, but believed the Medication Technicians did. On 06/26/25 at 11:11 AM, R19's family member verbalized the Wellness Director documented on 09/08/24 via text message that the facility would keep R19's cigarettes and lighter in the medication room after R19 had lit their mail on fire. The Wellness Director reported facility staff would escort R19 outside and light R19's cigarette for them. Severity: 2 Scope: 1 Complaint #NV00074279		designee will conduct a weekly check to ensure incident reports have been completed for any reported incidents for the next 60 days, and if substantial compliance is observed, periodically thereafter.	
0050 SS= J	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	0050	*What corrective actions will beaccomplished for those residents found to have been affected by the deficientpractice:* •□□□□□□R19 who was directly affectedby	08/20/2025

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	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 interview, record review, and document review, the Administrator failed to provide oversight and direction to members of the staff of the facility to ensure a resident who had behaviors of lighting items on fire received protective supervision for 1 of 15 sampled residents. (Resident #19) Findings include: Resident #19 (R19) R19 was admitted to the facility on 01/30/23, with diagnoses including bipolar disorder and depression. On 06/04/25 at 9:05 AM the smoking area was observed to be free of flammable items such as oxygen. A group of residents were smoking under the gazebo. There was a fire blanket available however no staff were present in the smoking area. A text message dated 09/08/24 at 7:05 PM, from the Wellness Director to R19's family member documented the facility took R19's lighter away because R19 had lit their mail on fire in their room. The Wellness Director explained the facility would keep R19's cigarettes and lighters in the medication room where R19 could come and ask for them when needed. The Wellness Director documented the facility would then go out and light the cigarette for R19. The text message lacked documented evidence that the facility would provide staff supervision while R19 was smoking. R19's file lacked documented evidence that the physician was notified of this behavior. R19's person-centered service plan lacked documented evidence there was an assessment for the behavior of lighting items on fire and had no provisions for supervision when the resident was smoking. The facility's Assisted Living Facility Smoking Evaluation with an effective date of 11/29/24 documented, R19 had no cognitive loss, no visual deficit, no dexterity problems, and no balance problems. R19 was documented as having		the deficient practice is no longer residing at the community. *Whatmeasures or systemic change will be put into place to ensure the deficientpractice does not reoccur:* •□□□□□□On 4/15/2025, an in-service forall staff regarding smoking safety was conducted by Fire safety services anoutside service. The in-service included education on fire blankets that thecommunity purchased the Inservice included when and how to use the fireblankets along with some return demonstration. •□□□□□□On 4/15/2025, all staff werere-educated to report any observed resident unsafe smoking practices tosupervisor. •□□□□□□Signs have been placedthroughout Community's designated smoking areas that remind residents that thesharing of lighters and cigarettes is prohibited. *How will the corrective action be monitored toensure the deficient practice will not reoccur:* •□□□□□□Upon move-in of any newresidents that smoke, Executive Director and/or designee will conduct a careconference to go over resident's smoking evaluation and community policy andprocedure regarding smoking. This will be documented in the residents HER filefor record.	

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	smoked seven times per day and smoked in the morning, afternoon, evening and nighttime. R19 could not light their own cigarette, would obtain smoking materials from family and friends and could safely smoke independently A Facility Incident Report dated 04/13/25 documented kitchen staff called for the Medication Technician (Med Tech) to go to the gazebo due to a fire. When the Med Tech got there, R19 was on fire. R19 was burned from the waist up. R19's clothing was ripped away and then the remaining fire was patted out. 911 was called and the resident was taken to a local hospital. On 06/04/25 at 9:06 AM, Resident #17 (R17) verbalized a Med Tech told them to not give R19 a lighter because R19 was burning other things. R17 knew not to give R19 cigarettes or a lighter. R17 believed R19 was fascinated with fire and reported observing R19 light the strings on the waist of their sweatpants on fire about a month before the 04/13/25 incident. On 06/04/25 in the afternoon, the Administrator reported they were unaware of this incident. On 06/04/25 at 9:08 AM, Resident #5 (R5) reported R19 had previously set fire to R19's mail sometime in August 2024. According to R5, the Administration told them not to give R19 cigarettes or a lighter. R5 verbalized R19 was always trying to bum a cigarette. R5 reported suddenly seeing R19 on fire on 04/13/25 when several Med Techs came outside to put R19 out. R5 was unaware how the fire started, but acknowledged R19 got their cigarette on the day of the incident from a Med Tech. On 06/04/25 at 9:10 AM, Resident #15 (R15) verbalized it was widely known R19 could not have lighters and R19 was always asking R15 for a light and cigarettes. On 06/04/25 at 9:19 AM, Resident #18 (R18) reported being told by staff to not give R19 a lighter and stated R19 had an incident previously in their room with fire where staff had to intervene. On 06/04/25 at 9:27 AM the Wellness Coordinator reported the facility told residents not to give R19			

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	cigarettes and lighters. According to the Wellness Coordinator, R19 tried to set R19's mail on fire around late August of 2024 and they took away the cigarettes and lighter after that incident. The Wellness Coordinator was unable to provide a supervision plan to keep R19 safe while R19 was in the smoking area smoking. On 06/04/25 at 9:38 AM, a Med Tech reported R19 was not allowed to have a lighter and that staff would light the cigarette for them. According to the Med Tech, R19 had a previous incident where R19 attempted to light something on fire in their room. On 06/04/25 at 9:41 AM, a Med Tech reported R19 would come to the Med Room for a lighter and cigarettes. The Med Tech reported all residents knew not to give R19 a cigarette or lighter. On 06/04/25 at 11:00 AM, the Wellness Director verbalized R19 had a habit of just flicking R19's lighter on and off and smoking in R19's room. The Wellness Director reported communicating with the R19's family member about the issue. The Wellness Director acknowledged hearing about an incident around the end of August of 2024 where R19 lit something on fire and a staff member put the fire out. According to the Wellness Director, R19 got a lighter from R19's roommate on the day of the 04/13/25 incident. R19's roommate was discharged at the time of the investigation and not available to interview regarding this statement. On 06/05/25 at 2:20 PM, a Caregiver reported the facility took R19's cigarettes and lighter away after an incident in August of 2024. The Caregiver explained they were working when R19 lit R19's mail on fire in R19's room. The Caregiver then ran over and put the fire out. No staff reported there was a plan for staff supervision while R19 was in the gazebo in the smoking area actively smoking other than notifying other residents to not give R19 lighters and cigarettes. The facility lacked documented evidence R19 caught themselves on fire with the lighter or the lit cigarette on 04/13/25. The staff and the			

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	residents who were present could not report how R19 caught themselves on fire. Hospital Records dated 04/13/25 documented that R19 presented to the emergency room for severe burns after being found on fire in the courtyard of the assisted living where R19 resided. R19 reportedly had a history of lighting cigarettes and clothes on fire. R19 was pending transfer to the Burn Intensive Care Unit for further care. R19 was diagnosed with burns to 33% of R19's Total Body Surface Area (TBSA) with 8% third degree burns to face, anterior and posterior torso, bilateral upper extremities, left lower extremity, and bilateral hands that occurred on 04/13/25 when smoking a cigarette. An email dated 06/06/25 at 8:42 AM from a hospital Social Worker documented R19 endured the following burn procedures due to the injuries sustained from the 04/13/25 incident: 04/14/24 debridement and application of restrata, Amnion-Chorion Membrane (ACM) and allograft to bilateral upper extremities and anterior trunk. 04/16/25 debridement application of restrata, ACM and allograft to face. 04/21/25 debridement and application of restrata, ACM, allograft to posterior torso. 04/23/25 debridement and application of restrata, ACM allograft to anterior torso. 04/28/25 debridement and application of restrata, ACM allograft to posterior torso. 04/30/25 debridement and application of restrata, ACM, allograft to anterior torso. 05/05/25 debridement and application of restrata, ACM, allograft to posterior torso. 05/07/25 debridement and application of ACM and amnion to face and restrata, ACM, allograft to anterior torso. 05/12/25 debridement and application of ACM and amnion to face and restrata, ACM, allograft to anterior torso. 05/16/25 debridement and application of ACM and amnion to face and restrata, ACM, allograft to anterior torso. 05/20/25 debridement and application of ACM and amnion to face and restrata, ACM, allograft to posterior torso. 05/22/25			

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		A. BUILDING _____ B. WING _____	**06/04/2025**

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	debridement and application of restrata, ACM and allograft to anterior torso. 05/27/25 debridement and application of restrata, ACM, allograft to posterior torso and debridement with wound vac to sacrum. Hospital records dated 06/03/25 documented R19 had a left thumb amputation on 05/29/25 and a right thumb amputation on 06/02/25 due to the extensive burns. On 06/03/25, R19 was discharged to an inpatient hospice. Hospice Clinical Notes dated 06/03/25 documented R19 presented to a local hospital on 04/13/25 with severe burns after being found on fire in the courtyard of the facility where R19 resided. R19 reportedly had a history of lighting cigarettes and clothes on fire. R19 was admitted for burns to bilateral upper arms, chest, back neck, and left leg. R19 underwent a tracheostomy due to the requirement of multiple debridements and intubations. R19's tracheostomy and PEG (Percutaneous Endoscopic Gastrostomy) were inserted on 04/18/25. R19 had multiple operations, debridement, and application of restrata and allograft to face, anterior torso, and posterior torso. R19 arrived to the hospice facility bedbound with a Foley catheter, 2nd degree burns to face, arms, torso, back and left leg. Also, R19 had a stage 2 wound to R19's sacrum with a wound vac. Hospice Clinical Notes documented R19 was passed away on 06/05/25. On 06/26/25 at 11:11 AM, R19's family member verbalized R19 had passed away due to burns they received while lighting a cigarette at the facility on 04/13/25. According to R19's family member, the Wellness Director documented on 09/08/24 via text message that the facility would keep R19's cigarettes and lighter in the medication room after R19 had lit their mail on fire. The Wellness Director reported facility staff would escort R19 outside and light R19's cigarette for them. The family member reported R19 had no issues with fire prior to the incident where R19 caught the mail on fire. Facility			

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	Protective Supervision Policy (no date) documented the facility shall provide each resident with protective supervision as necessary. Severity: 4 Scope: 1 Complaint # NV00074279			

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0170 SS= E	Health And Sanitation-Safe Water & Sewage - NAC 449.209 Health and sanitation. (NRS 449.0302) 1. A residential facility must: (a) Have a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage. Inspector Comments: Based on observation and interview, the facility failed to ensure hot water was available to residents in half of the facility. Findings include: On 06/05/25 from 9:45 AM to 10:00 AM, water temperatures were taken throughout the facility and temperatures were noted below, the Wellness Coordinator confirmed the temperatures taken. -Room 45.0 Shower temp 96 Fahrenheit (F). -Room 46.0Shower temp 94 F. -Room 49.0 Shower temp 96 F. -Room 52.0 Shower 94 F On 06/04/25 at 10:00 AM, multiple residents indicated the facility had an issue with water not being hot in the shower. On 06/04/25 at 10:05 AM, a resident indicated the water in the shower was not hot. On 06/04/25 at 11:45 AM, the Maintenance Director indicated the water temperatures may be lower during the morning when multiple people were taking showers, but the facility had no plan to ensure the water in the resident showers were at a highter temperature. Severity: 2 Scope: 2 Complaint #NV00073753	0170	*Date of correction* •□□□□□□6/4/2025 water temperature corrected for all affected rooms. *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* •□□□□□□By the end of 6/4/2025, all resident rooms' water temperatures were rechecked and are were adjusted if needed to ensure they were in the acceptable range of 100(F)-112(F). Results of there-checks and final adjustments were sent to inspector. *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□ □ □ □Σταρτινγ ον 8/20/25, the Maintenance Director and/or designee is conducting weekly checks of up to 10 rooms for low temps for 60 days and if substantial compliance is observed quarterly thereafter. *How will the corrective action be monitored to ensure the deficient practice will not reoccur:* •□□□□□□Executive Director and/or designee is conducting bi-weekly checks with maintenance director of up to 10 rooms for low temps for the next 60 days, and if substantial compliance is observed, periodically thereafter.	08/20/2025

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0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure a bathroom was properly cleaned and sanitized for 1 of 15 residents (Resident #9). Findings include: Resident #9 R9 was admitted on 04/14/25 with generalized weakness and incontinence. Review of R9's medical record revealed R9 was incontinent and required staff assistance for toileting. On 06/04/25, in the morning, the bathroom of R9 was observed with dried feces throughout, which included the floors, shower and toilet. On 06/04/25, in the morning, a Caregiver indicated R9 was incontinent, but refused any staff assistance with toileting. On 06/04/25, in the morning, a Wellness Coordinator indicated R9 was incontinent and would have accidents at least once a week where they didn't make it to the toilet. R9's file lacked documented evidence of a plan to ensure the resident's bathroom did not have feces due to the resident's issue with incontinent of bowel. On 06/04/25, in the morning, a housekeeper confirmed there was dried feces throughout the bathroom of R9. Severity: 2 Scope: 1 Complaint #NV00074348	0178	*Date of correction* *6/4/25* *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* •□□□□□□R9's bathroom was cleaned by housekeeper on 6/4/25. R9's plan of care was updated to increase housekeeping days to three times a week. *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□□□□□□Housekeepers and care staff-educated on reporting resident needs for additional cleaning on 8/10/25. •□□□□□□Wellness Director will ensure the updating of the resident care plan. If more frequent cleaning is needed based on resident care needs. *How will the corrective action be monitored to ensure the deficient practice will not reoccur:* •□□□□□□Maintenance Director and/or designee will conduct a weekly check to ensure bathroom cleaning for the next 60 days and if substantial compliance is observed, periodically thereafter.	08/20/2025
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	0255	*Date of correction* *6/10/25*	08/20/2025

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	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 06/04/2025 facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. There were multiple dead flies on the windowsill near the serving line. 2. Major Violations: a. A stainless-steel wall shelf was installed next to the dish machine and was used to hold clean ware. The shelf and was in close proximity to the soiled side of the dish machine which created the potential for contamination of clean ware and the location of the shelf made it difficult move around in and access the dish wash area. b. The inside of the cabinets across from the main kitchen which were used for food storage were soiled with debris and spillage. c. Both dumpster enclosures were soiled with leaves and debris and the generator enclosure between the dumpster enclosures was littered with cardboard boxes. 3. Equipment and Maintenance Violations: a. The countertop refrigerator used to hold snacks such as sandwiches, fruit and juice was not rated for sanitation or commercial grade. Severity: 2 Scope: 3		*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* •□□□□□□No residents were affected by this deficient practice. •□□□□□□Deep cleaning conducted by community including all cabinets and windowsills. Equipment was moved around, and wall shelf was extended out away from dishwashing machine. Dumpster areas was power washed, and all cardboard boxes have been removed. Countertop refrigerator was removed. *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□□□□□□The Dietary Director and/or designee will conduct a weekly check of kitchen with a checklist of areas of note to maintain cleanliness. •□□□□□□Dietary Director is responsible to ensure dumpster cleanliness, and a monthly deep cleaning of the dumpster was scheduled in the property management system (TELS). *How will the corrective action be monitored to ensure the deficient practice Will not reoccur:* •□□□□□□Executive Director and/or designee will conduct bi-weekly checks of kitchen area and dumpster areas for the next60 days and if substantial compliance is observed, periodically thereafter.	

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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 received a two-step tuberculosis (TB) test (Resident #15). Findings include: Resident #15 (R15) R15 was admitted on 11/08/24, with diagnoses including depression and a displaced fracture of the humerus. R15's record documented a completed TB test on 10/12/24 with a negative result. R15's record lacked documented evidence of a completed two-step TB test upon admission. On 06/04/25 in the afternoon, the Wellness Director acknowledged R15's file lacked documented evidence of a second TB test. Severity: 2 Scope: 1	0936	*Date of correction* *R15 TB started 6/4/25 completed 2nd step 6/14/25* *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* •□□□□□□R15'S two step TB was administered and is in resident's current file. *What measures or systemic change will be put into place to ensure the deficient practice does not reoccur:* •□ □ □ □Τηε Ωελλνεσσ Director and/or designee will conduct a weekly check of all new resident admission files for completion of TB process. This will include a move in process checklist that will be used for future new admissions. *How will the corrective action be monitored to ensure the deficient practice Will not reoccur:* •□□□□□□Executive Director and/or designee will conduct bi-weekly checks of new resident admission files for the next 60days to ensure all regulator required items are completed and if substantial compliance is observed, periodically thereafter.	08/20/2025