STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9538	A. BUILDING _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, ASSISTED LIVING AND MEMORY CARE	1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory re-grading survey and Facility Reported Incident (FRI) investigation completed at your facility on 10/16/2025. The facility is licensed for a total of 150 Residential Facility for Group beds: 126 beds for elderly and disabled persons and/or assisted living services, Category II residents and 24 beds for persons with Alzheimer's disease, Category II Alzheimer's residents. The census at the time of the survey was 103. 14 resident files were reviewed. The facility received a grade of B. There was one FRI was investigated. FRI #12241 was substantiated (See Tags Y0556 and Y0590).			
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or	Y 0172	1) fridge and common areas were cleaned 2) this cleaning task has been added as an additional task on the med tech list. 3) monitoring of the fridge by med techs. Ensuring the cleanliness of the interior and exterior of the premises, maintenance will monitor, and schedule outside agency's to assist as needed. 4) MT,MD,MCD, ED or designee 5) 10/17/2025 6) N/A 7) N/A	10/17/2025

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	insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 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 and interview, the facility failed to keep a refrigerator, storing resident medications, in sanitary condition and ensure the premises were clean and that the interior, exterior and landscaping of the facility were well maintained. Findings include: On 10/16/2025 at 9:43 AM, located in the locked unit medication refrigerator, were two medications stored to administer to			

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	residents. There was a tray under the freezing compartment and on the tray was a dry, sticky, green substance. The Memory Care Director could not remove the tray when tugging on the tray. Located in the bottom of the refrigerator was a green, sticky, dry substance. Stuck to the substance were strands of human hair and black particles. The black particles could not be identified. The Memory Care Director confirmed the medication refrigerator was dirty and explained the Medication Technicians were responsible for cleaning the refrigerator when conditions were unsanitary. The Memory Care Director verbalized the cleanliness of the medication storage refrigerator was an infection control concern because resident medications were being kept in the refrigerator and administered to the residents. The Memory Care Director was unsure what cleaning products would be used to clean the refrigerator. On 10/17/2025, the following maintenance concerns were identified: - At 9:29 AM, in the Quail Lodge Kitchen common area, the middle windowsill was loaded with dirt, spider webs, and had a dead bug. - At 9:43 AM, the corner next to the entrance was loaded with spider webs. - At 9:45 AM, the patio of Room 110 was loaded with spider webs. On 10/17/2025 at 9:29 AM through 9:45 AM, the Sales Director confirmed there were cobwebs on the exterior and interior of the building. The Sales Director confirmed the above-mentioned concerns and verbalized the facility had recently power washed the facility. This was a repeat deficiency from the 07/31/2025 annual State Licensure survey. Severity: 2 Scope: 3			

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Y 0590 SS= D	**NAC 449.268** **Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response.** 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility; (c) The residents are treated with respect and dignity; (d) The facility is a safe and comfortable environment; (e) Residents are not prohibited from interacting socially; (f) Residents are allowed to make their own decisions whenever possible; (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner; (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new roommate; and (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document.	Y 0590	1) All staff were re-educated on abuse prevention that includes recognizing, preventing, and immediately reporting any suspected abuse. All staff retrained on how to identify residents who are at risk for behaviors resulting in physical or verbal altercations. ED/HWD reviewed policies with staff to reinforce expectations related to resident rights, and protection from abuse. 2) Staff training on reporting guidelines, update care plans to reflect residents assessed needs and changes of condition, ongoing communication with staff to reinforce expectations regarding abuse. All existing and new staff to complete initial/annual Elder Abuse training. 3) ED/HWD will conduct periodic staff observations, review incident reports daily and ensure required training is completed. 4)ED, HWD or designee 5) 10/17/2025 6) N/A 7) N/A	10/17/2025

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	2. The administrator of a residential facility shall provide a procedure to respond immediately to grievance, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken. 3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2. Inspector Comments: Based on record review, interview and document review, the Administrator failed to ensure residents in the memory care unit were free from physical abuse from 1 of 14 sampled residents (Resident #14). Findings include: Resident #13 Resident #13 was admitted to the facility on 03/07/2023, with a diagnosis of dementia. Resident #14 Resident #14 was admitted to the facility on 07/17/2025, with diagnoses including atrial fibrillation and Alzheimer's disease. A Facility Reported Incident (FRI) dated 09/13/2025, documented an incident of resident-to-resident abuse. Resident #14 was aggressive toward Resident #13. Resident #13 lashed out in self-defense. Resident #14 was sent to the Emergency Room (ER) and later returned to the facility. Action steps taken to prevent future			

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	occurrences included changes to medications, separating Resident #14 in an area where the resident could be alone or with only 1-2 other residents, and looking into possible alternative placement if medications were not “kicking in”. An Incident Report dated 09/13/2025, documented Resident #14 was in an altercation with another resident in the memory care unit. Resident #14 struck Resident #13 with a cane multiple times. Resident #13 then struck Resident #14 multiple times. The residents were separated, and Emergency Medical Services (EMS) were called. Resident #14 was transported to the emergency room due to multiple bleeding injuries and being on a blood thinner. An Incident Report dated 10/12/2025, documented the resident in room 14A reported Resident #14 came into the resident’s room and turned on the light. The resident in room 14A screamed and yelled. Resident #14 then slapped the resident in room 14A on the left side of the resident’s face. On 10/16/2025 at 2:26 PM, the Executive Director (ED) verbalized there were several types of abuse including verbal, physical, exploitation, and resident-to-resident. Some examples of physical abuse included using a body part to hurt someone and throwing a chair at someone. The ED verbalized a resident slapping another resident in the face would probably be considered abuse, depending on the situation, and was a reportable incident. The facility’s process, if there was suspicion of abuse or an allegation of abuse was reported, was to ensure the resident was safe, enter an incident report, notify the ED’s supervisor, and fax a report to the State Agency (SA). The ED explained the ED tried to report suspicion and allegations of abuse to the SA within 24-48 hours of the incident or receiving the allegation however, if the incident happened over a weekend the ED may not receive the report right away. Following the resident-to-resident abuse			

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	incident reported by the facility on 09/13/2025, the ED explained interventions put in place by the facility to prevent future abuse included educating staff on redirection of residents, utilization of as needed (PRN) medications when necessary, reaching out the Health and Wellness Director for assistance with clinical questions, and changes to Resident #14's medication regimen. The ED verbalized staff's use of redirection with Resident #14 and the changes to the resident's medications were successful. The ED verbalized the ED was not aware of the incident documented in the 10/12/2025 Incident Report. The ED denied the incident had been investigated by the facility, reported to any required agencies, and denied the facility had implemented a plan or any interventions specific to the incident to ensure abuse did not recur. The facility policy titled "Abuse and Neglect Reporting Guidelines," revised 12/2023, documented abuse was as any act or failure to act performed intentionally or recklessly which caused or was likely to cause harm to a resident, including infliction of physical or mental injury. If abuse was suspected, staff were to immediately protect the resident from additional harm and call a supervisor as soon as possible. Staff were to complete an incident report and document in the resident's service notes. Initiation of an investigation included interviewing associates on duty at the time the alleged abuse occurred and/or the associate must have completed a written statement prior to leaving shift and an interview with all residents in the area. It was the responsibility of each community associate to assure compliance with abuse or suspected abuse reporting regulations. FRI #12241. Severity: 2 Scope: 1			
Y 0556 SS= D	NAC 449.262 and R043-22	Y 0556	1) The event on 10/12 was not promptly reported to the ED, and State Agency, the incident was immediately reviewed, documented and submitted to the State	10/17/2025

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	2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on record review, interview, and document review the facility failed to ensure an allegation of resident-to-resident physical abuse was reported to the Aging and Disability Services Division (ADSD) or law enforcement as described in Nevada Revised Statute (NRS) 200.5093. Findings include: Resident #14 Resident #14 was admitted to the facility on 07/17/2025, with diagnoses including atrial fibrillation and Alzheimer's disease. Resident #14's clinical record included a Fax Medical Doctor (MD) Notification Form dated 10/12/2025. The Form documented Resident #14 was involved in an altercation with another resident. Resident #14 entered another resident's room and turned on the light. The other resident began to scream as the resident was frightened. Resident #14 then allegedly slapped the other resident in the face. An Incident Report dated 10/12/2025, documented the resident in room 14A reported Resident #14 entered room 14A and turned on the light. The resident in room 14A screamed and yelled. Resident #14 then slapped the resident in room 14A on the left side of the resident's face. There was no documented evidence the facility reported the allegation of abuse to ADSD or law enforcement. On 10/16/2025 at 2:26 PM, the Executive Director (ED) verbalized there were several types of abuse including verbal, physical, exploitation, and resident-to-resident. Some examples of physical abuse included using		agency as a FRI. The ED ensured that both residents involved were assessed for safety and well being. All staff on duty during the incident were re-educated on the requirement to immediately report all allegations or suspicions of abuse directly to the ED or designee. 2) The community has implemented corrective measures: - updated the reporting guidelines, including resident to resident incidents, must be immediately reported to the ED or MOD prior to end of shift - added a written decision tree to the communication board. - conducted in service training with all staff timely reporting requirements 3) Review all incident reports daily, to ensure any necessary reporting is complete. 4) ED, HWD, MCD, RCC, or designee. 5) 10/17/2025 6)Decision Tree (Exhibit 1) 7) NA	

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	a body part to hurt someone and throwing a chair at someone. The ED verbalized a resident slapping another resident in the face would probably be considered abuse, depending on the situation, and was a reportable incident. The facility's process, if there was suspicion of abuse or an allegation of abuse was reported, was to ensure the resident was safe, enter an incident report, notify the ED's supervisor, and fax a report to the State Agency (SA). The ED explained the ED tried to report suspicion and allegations of abuse to the SA within 24-48 hours of the incident or receiving the allegation however, if the incident happened over a weekend the ED may not receive the report right away. The ED verbalized the ED was not aware of the incident involving Resident #14 and the resident in room 14A, as documented in the 10/12/2025 Incident Report. The ED denied the incident had been reported to ADSD or law enforcement as required and investigated by the facility. The facility policy titled "Abuse and Neglect Reporting Guidelines," revised 12/2023, documented abuse was any act or failure to act performed intentionally or recklessly which caused or was likely to cause harm to a resident, including infliction of physical or mental injury. If abuse was suspected, staff were to immediately protect the resident from additional harm, call a supervisor as soon as possible, follow state regulations on reporting, complete an incident report and initiate an investigation. It was the responsibility of each community associate to assure compliance with abuse or suspected abuse reporting regulations. Severity: 2 Scope: 1			
Y 0920 SS= D	NAC 449.2748 Medication Storage.	Y 0920	1) • OTC medications for residents #2, #4 and #12 were labeled with prescribing physician's name. • Medications were secured for	10/17/2025

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	1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure 1) over-the-counter (OTC) medications were labeled with the name of the prescribing physician for 2 of 14 sampled residents (Residents #2, #4, and		residents #5 and #9; residents were reminded that medication must be secured at all times per their signed ultimate user agreement. • Staff involved in incident were immediately counseled and retrained on proper medication administration procedures, including maintaining supervision of medication at all times and ensuring medication are never left unattended or accessible to residents. A review of medication administration practices was conducted with staff to reinforce the requirement that meds must remain secured and under staff supervision during medication pass. • 2) Staff education and retraining regarding requirements for proper labeling of OTC medications. • Residents who self administer and keep any medications in their apartment will sign ultimate user agreement upon move in or change in medication administration status and be provided a locked space to store medications. • All medication technicians will be trained initially and annually on proper medication pass protocol. 3)ED/ HWD or designee will conduct increased audits of all medication storage, proper OTC labeling and med pass observations to ensure medications are properly supervised and secured during administration. 4) HWD, MCD, RCC ED or designee 5)10/17/2025 6) N/A 7) N/A	

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	#12), 2) medications were secured for 2 of 14 sampled residents (Residents #5 and #9), and 3) medications were inaccessible to residents in the memory care unit and staff provided adequate supervision during medication administration when 1 of 14 sampled residents (Resident #14) ingested medications which were not prescribed to the resident. Findings include: Label Resident #2 Resident #2 was admitted to the facility on 09/12/2025, with diagnoses including chronic constipation and dementia. A list of physician orders, dated 09/12/2025, documented the following: -Dorzolamide Hydrochloride and Timolol Maleate 2%. Instill one drop into each eye twice daily. -Brimonidine 0.2%. Instill one drop into each eye twice daily. -Levothyroxine 75 micrograms (mcg). Take one tablet by mouth every morning on an empty stomach. On 10/16/2025 at 1:36 PM, during a review of Resident #2's medications and in the presence of a Medication Technician (Med Tech), OTC bottles of Dorzolamide, Brimonidine and Levothyroxine were present among Resident #2's medications. The bottles were not labeled with the name of the prescribing physician. On 10/16/2025 at 1:36 PM, the Med Tech explained OTC medications were to be labeled with the resident's name and the physician's name. The Med Tech confirmed Resident #2's Dorzolamide, Brimonidine, and Levothyroxine were not labeled with the name of the prescribing physician. Resident #4 Resident #4 was admitted on 08/07/2025 with diagnosis of primary progressive aphasia with dementia.			

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	Resident #4's October 2025 Medication Administration Record (MAR) and physician order dated 08/25/2025 documented nutritional supplement liquid, take 237 milliliters by mouth every day. Family will provide supplement. May substitute similar nutritional supplement shake such as Boost or generic brand. Resident #4's Ensure (nutritional supplement) contained a room number; however, lacked the required resident name and ordering provider name. Resident #4's October 2025 MAR documented Treatment Formula 3 Antifungal. Apply thin layer on the first three toes of the right foot in the morning at night. Resident #4's Treatment Formula 3 Antifungal container lacked the provider's name. On 10/16/2025 at 12:11 AM and 12:15 AM, respectively, the Med Tech confirmed the OTC medications lacked all required information. Resident #12 Resident #12 was admitted to the facility on 07/25/2025, with diagnoses including hypothyroidism and dementia. A medication review report, dated 07/23/2025, documented Vitamin D3 125 mcg capsule. Take one capsule by mouth daily. On 10/16/2025 at 12:53 PM, during a review of Resident #12's medications and in the presence of a Med Tech, there was an OTC bottle of Vitamin D3. The bottle was not labeled with the name of the prescribing physician. On 10/16/2025 at 12:53 PM, the Med Tech confirmed Resident #12's Vitamin D3 medication bottle lacked the name of the prescribing physician.			

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	9538	A. BUILDING _____ B. WING _____	10/16/2025

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	Secure Resident #5 Resident #5 was admitted to the facility on 08/15/2025, with diagnoses including diabetes, hypertension, and hyperlipidemia. Resident #5's clinical record included an Ultimate User Agreement, dated 08/11/2025, documenting the resident designated the facility's employees to possess, administer and monitor the resident's medications. On 10/16/2025 at 10:02 AM, Resident #5's was not present in the resident's room and the following medications were found on the resident's bedside table: -One bottle Niacinamide 10 milligrams (mg) and Vitamin B6 2.5 mg capsules. -One bottle Guaifenesin 200 mg. -Two tubes Clotrimazole cream. -One bottle Azelastine Hydrochloride (HCl) nasal spray. On 10/16/2025 at 10:02 AM, the Resident Care Coordinator confirmed the medications were stored unsecured in Resident #5's room. Resident #9 Resident #9 was admitted to the facility on 07/28/2025, with diagnoses including cerebral ischemic attach and hydrocephalus. Resident #9's clinical record included an Ultimate User Agreement, dated 07/28/2025, documenting the resident designated the facility's employees to possess, administer and monitor the resident's medications. On 10/16/2025 at 10:08 AM, the Resident Care Coordinator explained Resident #9 did not self-administer their medications; however, Resident #9 shared a room with a resident who did self-administer medications. On 10/16/2025 at 10:35 AM, Resident #9			

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	nor the resident's roommate were present in the resident's room, and the following medications were found in an unlocked and accessible area of the suite: -One bottle Vitamin C 750 mg gummies. -Two boxes Collagen and Boron supplements. -One bottle L-Lysine tablets. -One bottle Nicotinic Acid 500 mg tablets. -Three bottles Ibuprofen 200 mg tablets. -Two bottles Aspirin 81 mg tablets. -One bottle Aspirin 325 mg tablets. -One bottle Naproxen Sodium 220 mg capsules. -One bottle Magnesium 250 mg tablets. On 10/16/2025 at 10:35 AM, the Resident Care Coordinator verbalized residents should not have unsecured medications stored in resident rooms to prevent other residents from accessing the medications and causing harm to the residents. The Resident Care Coordinator confirmed medications were stored unsecured in Resident #9's shared suite and were accessible to Resident #9. Resident #14 Resident #14 was admitted to the facility on 07/17/2025, with diagnoses including atrial fibrillation and Alzheimer's disease. Resident #14's Medication Management Authorization form dated 08/06/2025, documented the resident's representative designated the facility's employees to possess, administer, and monitor the resident's medications. An Evaluation for Placement in a Secured Environment signed by the physician on 09/02/2025, documented Resident #14 needed a secured environment and the resident would benefit from a secured environment due to the following: -Short-term memory. -Disoriented to time and place. -Does not recognize loved ones. -Unable to perform Activities of Daily Living (ADLs). -Aggressive behavior or verbal outburst. -Need for supervision.			

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	-Unable to self-medicate. -Difficulty with verbal communication. A Fax Medical Doctor (MD) Notification Form dated 09/26/2025, documented Resident #14 accidentally took Escitalopram 10 milligrams (mg), Levothyroxine Sodium 50 micrograms (mcg), and two tabs of Quetiapine Fumarate 25 mg in addition to the resident's regular medications. The resident's regular medications included two tabs of Acetaminophen 500 mg, Amlodipine Besylate 5 mg, Atenolol 50 mg, Olanzapine 2.5 mg. The resident threw up and had been sleeping. On 10/16/2025 at 2:16 PM, the Executive Director (ED) verbalized residents in the memory care unit were not supposed to have access to medications as no residents in the unit were appropriate to self-administer and a resident taking medications which were not prescribed to them could be the result of a medication administration error. On 10/16/2025 at 3:10 PM, the ED verbalized the ED found an incident report documenting a medication administration error occurred on 09/26/2025, resulting in Resident #14 taking another resident's medication. The ED explained the Med Tech left a resident with the medications and upon return, the Med Tech observed Resident #14 taking the medications. The resident and medications were not within the Med Tech's line of sight and were not under the supervision of any other staff qualified to administer medications at the time of the incident. The ED verbalized Resident #14 was sent to the ER the same day for evaluation due to ingestion of medications not prescribed to the resident. An Incident Report dated 09/26/2025, documented a Med Tech floated a resident's medication on the resident's breakfast. Prior to the resident consuming the breakfast and swallowing the medication, the Med Tech left the resident unattended in the dining room while the Med Tech responded to a bed alarm. Upon			

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	return, the Med Tech observed Resident #14 consuming the other resident's breakfast and medication. A Counseling Documentation Form dated 09/27/2025, documented the Med Tech left medications unattended in the presence of a resident in the memory care unit. Due to this, the medications were ingested by a resident for which the medications were not intended. Memory care residents often experienced varying levels of cognitive impairment and required close supervision during medication administration to ensure safety and compliance. Leaving medications unattended posed a significant safety risk including the potential for overdose, missed doses, or access by other residents. Severity: 2 Scope: 1			
Y 0878 SS= D	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with 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	Y 0878	1) Medication change order label for resident #3 was corrected day of inspection by applying change of direction sticker to medication container. Medication was obtained and placed in cart on 10/17/2025 for resident #9. 2) Staff education, emphasizing timely change order labels and ensuring medications are on site and available at all times. 3) Weekly cart audits by HWD or designee and immediate follow up with discrepancies to prevent future occurrences 4) ED/HWD, or designee 5) 10-17-2025 6) N/A 7) N/A	10/17/2025

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	practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, record review, and interview, the facility failed to 1) to complete a change order label for 1 of 14 sampled residents (Resident #3) and 2) to ensure 1 of 14 sampled residents (Resident #9)'s medications were onsite and available for administration. Findings include: Resident #3 Resident #3 was admitted on 08/07/2025 with diagnoses including trigeminal neuralgia, hyperlipidemia, Alzheimer's, and			

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	vascular dementia. Resident #3's October 2025 Medication Administration Record (MAR) documented Ibuprofen caplet 200 milligrams (mg), take two tablets by mouth three times a day as needed for pain, sore throat pain, and body aches for acute laryngitis unspecified; physician order dated 07/25/2025 documented take one tablet by mouth three times a day as needed for sore throat pain and body aches; and medication packet documented Ibuprofen caplet 200 mg tablets; take one tablet by mouth three times a day as needed for sore throat pain and body aches. On 10/16/2025 at 11:51 AM, the Medication Technician (Med Tech) confirmed the medication instructions on the MAR were different from the medication instructions on the physician order and the medication packet and verbalized the medication technician would refer to the order to confirm the correct dosage. Resident #9 Resident #9 was admitted to the facility on 07/28/2025, with diagnoses including cerebral ischemic attach and hydrocephalus. Resident #9’s October 2025 MAR documented Ezetimibe 10 mg tablet. Take one tablet by mouth two times a day for chronic atrial fibrillation unspecified. An Order Summary Report, dated 07/25/2025, documented Ezetimibe oral tablet. On 10/16/2025 at 1:10 PM, during a review of Resident #9’s medications and in the presence of a Med Tech, the Ezetimibe was not present among the resident’s medications. On 10/16/2025 at 1:10 PM, the Med Tech confirmed the Ezetimibe was not present and explained all medications should be onsite and available to be administered.			

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