Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9975	A. BUILDING _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MEADOWS RESIDENTIAL CARE HOME	13495 STONEY BROOK DR, RENO, NEVADA ,89511

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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 State Licensure annual grading survey conducted at your facility on 08/26/2025. This survey was conducted by the Health Care Purchasing and Compliance Division in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was ten. Ten resident records and six employee files were reviewed. The facility received a grade of B. The findings and conclusions of any investigation by the Health Care Purchasing and Compliance Division 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 deficiencies were identified:			
Y 0102 SS= D	NAC 449.200 and R043-22	Y 0102	1) How you will correct the	10/15/2025

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	(d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on personnel record review and interview, the Administrator failed to ensure an annual tuberculosis screening was completed for 1 of 6 employees (Employee #6), pursuant to Nevada Administrative Code, Chapter 441A. Findings include: Employee #6 Employee #6 was hired on 05/02/2024, as the Administrator. Employee #6's personnel file documented a QuantiFERON TB test on 12/08/2023, and read negative. Employee #6's personnel file lacked a TB test for 2024. On 08/26/2025 at 11:09 AM, the Administrator confirmed the 2024 TB test was not completed for Employee #6. The Administrator verbalized the TB tests were required for all employees upon hire and annually thereafter. Severity:2 Scope: 1		specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS) Answer: The correction of the specific finding by deficient practice: Yearly QuantiFERON test need to be completed. The facility failed to ensure that a QuantiFERON TB test done accordingly. The QuantiFERON blood test was done to correct this citation. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator will review all TB test documents yearly and the two steps of the TB test or the QuantiFERON blood test will need to be complete prior admission or hiring. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The administrator will review admission documents carefully prior admission and yearly after.	

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			4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 10/15/25. 6) You must attach all supporting documents into the system (MUST INCLUDE 1. Answer: Support documents: Employee#6 Negative result with the QuantiFERON TB test document.	
Y 0644 SS= C	NRS 449.184 1. A person who operates a residential facility for groups shall: (a) Post his or her license to operate the residential facility for groups; (b) Post the rates for services	Y 0644	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding by the deficient practice: The correct designee	09/26/2025

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	provided by the residential facility for groups; and (c) Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to post the accurate Administrator's designee with contact information in a conspicuous place in the facility. Findings include: On 08/26/2025 at 9:30 AM, a posting indicated who the designee would be if the person in charge of the facility was unavailable. On 08/26/2025 at 10:30 AM, the personnel file for the designee was requested; however, the file was unavailable. On 08/26/2025 at 10:44 AM, the Administrator confirmed the designee posted on the wall no longer worked for the facility and the incorrect designee was posted. Severity:1 Scope:3		was updated and posted on the wall immediately. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: The administrator will always ensure that the designee is updated at all time reflecting of the current management team. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The corrective action will be monitored to ensure the deficient practice will not recur by the administrator. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is	

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			implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 09/26/2025 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: Support documents: The place card for the administrator's designee	
Y 0526 SS= C	NAC 449.260 and RO43-22 Activities for residents. 1. The caregivers employed by a residential facility shall: (a)Ensure that the residents are afforded an opportunity to enjoy their privacy, participate in physical activities, relax and associate with other residents; (b)Provide group activities that provide mental and physical stimulation and develop creative skills and interests; (c) Plan recreational opportunities that are suited to the interests and capacities of the residents; (d) Provide each resident with a written program of activities; (e) Provide for the residents at least 10 hours each week of scheduled activities that	Y 0526	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding by the deficient practice: The updated calendar August 2025 was posted on the wall immediately. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Answer: We will put these	08/26/2025

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	are suited to their interests and capacities; (f) Encourage each resident to participate in the activities scheduled pursuant to his or her person-centered service plan; and (g) Post, in a common area of the facility, a calendar of activities for each month that notifies residents of the major activities that will occur in the facility. The calendar must be: (1) Prepared at least 1month in advance; and (2) Kept on file at the facility for not less than 6 months after it expires Inspector Comments: Based on observation and interview, the facility failed to post a current activities calendar for 10 of 10 residents. Findings include: On 08/26/2025 at 9:46 AM, during a tour of the facility, posted in the kitchen was an activities calendar. The calendar was dated “August 2023”. On 08/26/2025 at 9:47 AM, the Caregiver confirmed the posted activities calendar was for August of 2023 and verbalized the current activities calendar was to be posted at all times. Severity:1 Scope:3		systems in place to ensure the deficient practice does not recur: 1. The administrator will always ensure that the correct month/year of the calendar is displayed. 2. Monthly, the administrator/manager will review to accuracy of the month and year of the activity calendar. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: The corrective action will be monitored to ensure the deficient practice will not recur by the administrator. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is implemented. 5) The date the corrective action	

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			will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 08/26/2025 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: Support documents: The updated calendar of August 2025, and the current month of November 2025	
Y 0515 SS= D	NAC 449.259 **Supervision of residents.** 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. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will	Y 0515	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The correction of the specific finding by the deficient practice: The specific person-centered plan of care is created and specified in details that the resident is on hospice. The resident is still enjoying her outdoor activity with her daughter and including the resident prefers companionship and music sing-along. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice	11/01/2025

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	be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to ensure a person-centered service plan related to hospice services was developed to address the facility's treatment of residents for 1 of 10 sampled residents reviewed for service plans (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 05/29/2024, with diagnoses including Alzheimer's disease, cancer and arthritis. On 08/26/2025 at 11:51 AM, the		does not recur (MUST ADDRESS); Answer: The administrator always set up the system to ensure/update person centered plan of care document immediately when the resident condition has changed. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: We are scheduled to monitor the record monthly and immediately update the document to ensure the deficient practice will not recur and will be done by an administrator. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is implemented. 5) The date the corrective action	

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	Administrator confirmed the facility had not created a person-centered service plan related to the care and treatment of hospice services for Resident #7. Severity: 2 Scope: 1		will be completed (MUST INCLUDE); AND Answer: The new updated person centered plan of care of the corrective action was completed: 11/01/2025 6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: Support documents: updated the person-centered plan of care	
Y 1600 SS= C	**NAC 449.011943 and R004-24** **NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104)** 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and	Y 1600	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Answer: The Administrator failed to state preferred name and pronoun and in accordance with his or her gender identity or expression in writing on their record. Their preferred name, pronoun, gender identity or expression has been state in their record. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS);	09/26/2025

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	available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection1, include, without limitation: (a) The preferred name and pronoun ofthe patient or resident; (b) The gender identity or expressionof the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and		Answer: The administrator will ensure that their preferred name, pronoun, gender identity or expression are updated/completed upon admission. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Answer: By reviewing the admission record regarding to this topic and ensure the corrective action was addressed. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Answer: The administrator will be the responsible person to ensure the plan of correction is implemented. 5) The date the corrective action will be completed (MUST INCLUDE); AND Answer: The date of the corrective action was completed: 09/26/2025	

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	(e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure resident records reflected a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 10 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). Findings include: On 08/26/2025 in the morning, the clinical records for all residents in the facility lacked		6) You must attach all supporting documents into the system (MUST INCLUDE). Answer: Attached file of all of the resident name with the preferred name and pronoun and in accordance with his or her gender identity or expression	

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	documentation to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation. On 08/26/2025 at 11:51 AM, the Administrator confirmed all residents' clinical records lacked documentation to reflect a residents' preferred name, pronoun, gender identity or expression, and sexual orientation. Severity: 1 Scope: 3			