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
	11024	A. BUILDING _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY MANOR	7043 CALVERT CLIFFS ST, NORTH LAS VEGAS, NEVADA ,89084

(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
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 02/20/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds, with an endorsement to provide care for residents with Alzheimer's Disease and/or Assisted Living services, and/or Category II residents. The census at the time of the survey was six. Six resident files and five employee files were reviewed. The facility received a grade of A. 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:	0000		
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and document review, the facility failed to ensure a newly hired employee completed a two step tuberculosis (TB) screening for 1 of 5 Employees (Employee #3). Findings include: Employee #3 (E3) was hired on 04/09/24 as a Medication Technician. Review of E3's employee file revealed a TB test was completed on 03/26/24. There was no documentation a second TB test was completed for E3. On 02/20/25, in the morning, E3 confirmed they did not complete a two step TB test. Severity: 2 Scope: 1	0102	1. E3's 2-step Tb Test was initiated on 2/21/25 and completed on 3/4/25. Results came back negative for both steps. 2. Administrator and Owner will be more diligent in ensuring that new employees get a 2- step TB test initially and a one-step annually in order to be in compliance. 3. Administrator will do monthly audits of employee folders to ensure all requirements are up to date. 4. Administrator will ensure that the plan of correction is implemented. 5. On 3/4/25, the second step was read and resulted with a negative reading for E3. 6. Please see attached document.	03/04/2025

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ERNIE DIAZ Title: ADMINISTRATOR Date: 03/04/2025

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0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure bed rails were not used as a restraint for a resident for 1 of 6 residents (Resident #3). Findings include: Resident #3 (R3) was admitted on 02/15/25 with diagnosis including Alzheimer's disease. On 02/20/25, in the morning, R3 was observed in bed, with full bed rails in the raised position. Due to cognition R3 was not able to be interviewed. On 02/20/25, in the morning, the Owner revealed R3 did not use the rail for any purpose and the rail was in the up position to ensure R3 did not fall out of bed. Severity: 2 Scope: 1	0557	1. On 2/20/25, Immediately after the survey, both half rails for R3 was picked up by DME company and fall mats were placed by R3's bed. 2. Administrator, Owner and Caregivers are aware that bedrails are not to used by any residents in this facility at any time as they are considered as a restraint and is dangerous for the resident. 3. Owner and Caregivers are aware that the use of Bed Rails are not permitted for Resident Use. 4. Administrator is responsible in ensuring that the plan of correction is implemented. 5. On 2/20/25 in the afternoon, the bedrails on R3 were removed and replaced with Fall Mats. 6. No attached documents for this POC.	03/04/2025

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0874 SS= D	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 interview and record review, the Administrator failed to review and sign off on six month pharmacy reviews for 1 of 6 residents (Resident #6). Findings include: Resident #6 (R6) was admitted on 10/07/23 with diagnosis including cerebral vascular accident. Review of R6's medical record revealed Pharmacy Reviews were completed on 04/10/24 and 10/09/24. There was no documentation or signature to indicate the Administrator reviewed R6's Pharmacy Reviews. On 02/20/25, in the morning, the Owner confirmed the Administrator had not reviewed or signed off on R6's Pharmacy Reviews. Severity: 2 Scope: 1	0874	1. On 2/21/25, a Medication Review List was completed for R6 and Administrator reviewed and signed off. 2. Administrator and Owner will ensure that Medication Reviews are done no less than every 6 months for all residents and Administrator reviews for accuracy and signs off. 3. Administrator will conduct monthly audits that Medication Reviews are accurate and completed no less than every 6 months. 4. Administrator is responsible that the plan of correction is implemented. 5. On 2/21/25. 6. Please see attached document.	03/04/2025

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure all doors exiting the facility had an audible alam. Findings include: On 02/20/25, in the morning, a sliding glass door, which exits to the backyard, did not have a functioning audible alarm. On 02/20/25, in the morning, the Owner confirmed the alarm for the sliding glass door was not functioning because it was turned off and should not have been. Severity: 2 Scope: 3	0991	1. During the survey, Owner turned back on the alarm that was turned off. 2. A sign has been placed on the sliding by the alarm reminding all employees not to turn off the alarm for any reason. 3. Owner will monitor on a daily basis that the alarm on back door is always working. 4. Administrator is responsible for ensuring that the plan of correction is implemented. 5. On 2/20/25. 6. Please see attached document.	03/04/2025