

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER BETHANY AT MT HOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MOUNT HOOD ST, LAS VEGAS, NEVADA ,89110		
(X4) ID PREFIX TAG Y 0220 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NAC 449.213 Laundry and linen services. 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen service shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. 4. Clothes, bedding, linens and any other materials laundered pursuant to subsection 1 must be made clean by the laundering process. If a residential facility provides its own laundry and linen services, the residential facility shall: (a) Make appropriate use of detergents, soaps, heat or chemicals; and (b) Take precautions to ensure that no resident, member of the staff of the facility or other person in the facility is harmed by exposure to the detergents, soaps, heat or chemicals used in the laundering process.	ID PREFIX TAG Y 0220	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Immediately upon the owner being informed by the surveyor, the owner went out and purchased a new set of washer and dryer. The new equipment will assure the laundry will be done on the premises and will not have any further problems. The staff and owner will immediately call a repairman should either machine becomes non-working and resolve the issues. the staff and the owner will ensure this plan is maintained. The new set was purchased and installed by 03/11/2026. Photo of newly installed set included here. Other areas of facility operation will not be affected by this problem as it involves equipments being installed and staff will do the laundry on the premises daily.	(X5) COMPLETION DATE 03/11/202 6

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: ROSALIE KOWATCH- Title: RFA
BACAL

Date: 09/04/2026

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER BETHANY AT MT HOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MOUNT HOOD ST, LAS VEGAS, NEVADA ,89110		
(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
	Inspector Comments: Based on observation and interviews, the facility failed to provide laundry and linen services on the premises of the facility. Findings include: On 03/09/26 in the morning, inside of the laundry room of the facility a disabled dryer machine was observed, with no washer machine. On 03/09/26 in the morning, the Owner confirmed the drying machine in the laundry room was disabled and the facility did not have a washing machine. The Owner verbalized laundry linen services were being done at the owner's private home. The Owner then acknowledged since the facility was a licensed Residential Facility for Groups (RFG) a working washing and dryer machine was required on the premises of the facility to provide laundry and linen services. Severity: 2 Scope: 3			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER BETHANY AT MT HOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MOUNT HOOD ST, LAS VEGAS, NEVADA ,89110		
(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
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 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	Y 0878	The owner and med techs know suppositories may only be used on a resident by an RN. They know, no one else is allowed to insert this PRN medication into a resident's rectum. The RN from the Hospice Agency is also the one to re-order medications if something is running low, as the RN is supposed to visit at least once weekly. The med-tech also has been instructed to make sure to call the RN or the Hospice one week before a medication runs out, in case the RN is not there. This should not have run out. This is only a conjecture that most likely the RN used the last one on the patient and forgot to re-order. The Hospice RN was called immediately to re-order and supply was received by 03/11/2026, unfortunately, the resident passed away on 05:25 am on 03/11/2026 pronounced by Hospice RN. All resident's meds were checked to ensure all had sufficient supply and a list made of those needing imminent re-order. The owner (main med tech), and med tech staff will check that all meds of all resident's are in ample supply with daily pouring. The RFA routinely visiting about once weekly will also check the bins when checking the MAR binder. Moving forward, this issue will be prevented from happening again.	03/11/2026

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER BETHANY AT MT HOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MOUNT HOOD ST, LAS VEGAS, NEVADA ,89110		
(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
	(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, interview, and record review the facility failed to ensure medications were on-site and available for 1 of 8 sampled residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted to the facility on 12/26/25 with a diagnosis of dementia. A physician order dated 10/06/25, documented Bisacodyl 10 milligrams (mg) insert one suppository rectally as needed for constipation. On 03/09/26 in the morning, the medication was not observed in R3's medication storage bin. On 03/09/26, in the morning, the Owner verified the R3's			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER BETHANY AT MT HOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MOUNT HOOD ST, LAS VEGAS, NEVADA ,89110		
(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
	medication was not on-site because R3 had not needed the medication, so the facility had forgotten to refill the medication. The Owner acknowledged the medication should have been onsite if R3 would have needed it. Severity: 2 Scope: 1			