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
	8640	A. BUILDING _____ B. WING _____	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON TAHOE EXPRESSIONS MEMORY CARE	1001 MOUNTAIN ST, CARSON CITY, NEVADA ,89703

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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		

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: Lori Carlile	Title: Administrator	Date: 03/26/2026

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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 complaint investigation and an annual survey completed at your facility on 11/10/2025. The facility is licensed for 54 Residential Facility for group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, mental illness and intellectual disabilities, Category II residents and operated as Sierra Basin Memory Care. The census at the time of the survey was 43. 15 resident files and 10 employee files were reviewed. The facility received a grade of D.			

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Y 0050 SS= F	**NAC 449.194** **Responsibilities of administrator.** 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 needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, clinical record review, personnel record review, and interview, the Administrator failed to provide oversight and direction for employees to provide necessary needed services and protective supervision to residents. Findings include: Please see TAGs Y0065, Y0074, Y0102, Y0104, Y0450, Y0451, Y0690, Y0850, Y0878, Y0905, Y0920, Y0930, Y0994, Y1035, Y1540, and Y1840. Severity: 2 Scope: 3	Y 0050	**Y0050 - Administrator responsibilities** **Immediate correction:** The Administrator reviewed all cited deficiencies, initiated immediate corrective action for each cited area, and established a facility-wide compliance recovery plan on 03/23/2026. **How others were identified:** A 100% audit was initiated across personnel files, resident clinical files, medication storage/reconciliation, and environmental safety items to identify any additional areas affected by the deficient oversight system. **System change:** The facility implemented a centralized compliance matrix maintained by the Administrator/designee. The matrix tracks staff onboarding requirements, annual due dates, resident annual requirements, medication audits, and environmental rounds. No compliance item may be considered complete until documentation is present in the employee or resident record and validated by management. **Monitoring:** The Administrator will review the matrix weekly for 4 weeks, then monthly for 6 months. Findings and overdue items will be reviewed in QA/QAPI with documented follow-up.	04/30/2026
Y 0065 SS= E	**NAC 449.196 & R043-22** **Qualifications of caregivers:** 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities;	Y 0065	**Y0065 - Caregiver qualifications / initial and annual training** **Immediate correction:** Employee #11 was scheduled for and completed the required initial caregiver training, and Employees #5, #6, #8, and #9 were scheduled for and completed the required annual caregiver training hours. Personnel files were updated with proof of completion.	04/30/2026

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	(c) Understand the provisions of NAC 449.156to 449.27706,inclusive, *and sections 2 to 16,inclusive, of this regulation* and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and *(f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility;* and *(g)*Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training *must include, without limitation, at least 2 hours of tier 2 training.* Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1 of 11 sampled employees received the required 4 hours of initial caregiver training (Employee #11) and 4 of 11 sampled employees working at the facility one year or greater, completed at least eight hours of annual Caregiver training (Employee #5 #6, #8 and #9). Findings include: Employee #11 Employee #11 was hired by the facility as a Caregiver with a start date of 07/07/2025. Employee #11's personnel file lacked documented evidence of initial caregiver training completed within 60 days of hire.		**How others were identified:** A 100% audit of all direct-care staff was completed to verify completion of 60-day initial caregiver training and annual 8-hour training requirements, including required tier 2 content. **System change:** The facility implemented a new-hire training checklist and anniversary training tracker. Staff may not work independently after hire until required onboarding training is verified. The learning coordinator/Administrator will issue due-date notices at hire, 30 days, 45 days, 60 days, and 30 days before each annual due date. **Monitoring:** The Administrator or designee will audit the training log weekly for 4 weeks and monthly thereafter for 6 months.	04/30/2026

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	Employee #5 Employee #5 was hired by the facility as a Medication Technician with a start date of 08/01/2024. Employee #5's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. Employee #6 Employee #6 was hired by the facility as a Caregiver with a start date of 08/01/2024. Employee #6's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 10/01/2024. Employee #8's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. Employee #9 Employee #9 was hired by the facility as a Medication Technician with a start date of 08/01/2024. Employee #9's personnel file lacked documented evidence of eight hours of annual training for the care of elderly or disabled. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for initial and annual caregiver training. The Administrator explained the training records provided were what was available. The facility policy titled "Orientation and Training", undated, documented a learning coordinator would be assigned at each community to ensure annual training and			

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	state and federal required training were followed. All training would be sent, completed and documented through the facility platform. Severity: 2 Scope: 2			
Y 0074 SS= F	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually receive training to recognize and prevent theabuse of older persons before the license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse	Y 0074	**Y 0074 - Elder abuse training** **Immediate correction:** Employees #1, #4, and #11 were immediately reviewed and scheduled/ completed for required elder abuse training, and Employees #5, #6, and #9 were scheduled/ completed for annual elder abuse training. Documentation was placed in the personnel files. **How others were identified:** A 100% audit of all employees was completed to verify initial elder abuse training before resident care and annual renewal thereafter. **System change:** Elder abuse training was added to the onboarding hard-stop checklist and annual compliance matrix. No employee may provide resident care until the initial elder abuse training is documented. **Monitoring:** The Administrator/designee will audit the abuse-training roster weekly for 4 weeks and monthly for 6 months.	04/30/2026

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	of older persons before the facility, agency or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care, facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter. 6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section.			

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	8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection. 9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 3 of 11 employees received initial elder abuse training prior to providing care to residents (Employee #1, #4, and #11) and annual elder abuse training was completed timely for 3 of 11 employees (Employee #5, #6 and #9). Findings include: Employee #1 Employee #1 was hired on 10/22/2025 by the facility as the Administrator. Employee #1's personnel record lacked documented evidence of initial elder abuse training.			

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	Employee #4 Employee #4 was hired on 05/08/2025 by the facility as a Caregiver. Employee #4's personnel record documented a late initial elder abuse training completed 06/22/2025, after the employee began providing care to residents. Employee #11 Employee #11 was hired on 07/07/2025 by the facility as a Caregiver. Employee #11's personnel record lacked documented evidence of initial elder abuse training. Employee #5 Employee #5 was hired on 08/01/2024 by the facility as a Medication Technician. Employee #5's personnel record lacked documented evidence of annual elder abuse training having been completed for 2025. Employee #6 Employee #6 was hired on 08/01/2024 by the facility as a Caregiver. Employee #6's personnel record lacked documented evidence of annual elder abuse training having been completed for 2025. Employee #9 Employee #9 was hired on 08/01/2024 by the facility as a Medication Technician. Employee #9's personnel record lacked documented evidence of annual elder abuse training having been completed for 2025. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for initial and annual elder			

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	abuse training. The Administrator explained the training records provided were what was available. The facility policy titled "Orientation and Training", undated, documented a learning coordinator would be assigned at each community to ensure annual training and state and federal required training were followed. All training would be sent, completed and documented through the facility platform. Severity: 2 Scope: 3			
Y 0104 SS= F	**NAC 449.200** **Personnel files** (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on employee record review and interview, the facility failed to ensure 8 of 11 employees background check clearance per the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 were for the appropriate facility (Employee #1, #2, #3, #5, #7, #8, #10, and #11). Findings include: The following employees background checks were completed for a different facility. -Employee #1 had a hire date of 10/08/2024, and a title of Administrator. -Employee #2 had a hire date of 11/03/2025, and a title of Health Services Director. -Employee #3 had a hire date of 07/07/2025, and a title of Caregiver. -Employee #5 had a hire date of 08/01/2024, and a title of Medication Technician.	Y 0104	**Y0104 - Personnel files / background clearance** **Immediate correction:** Employees identified with background clearance letters tied to the wrong facility were immediately reviewed, and corrected facility-specific clearance documentation was requested/obtained and filed as applicable. **How others were identified:** A 100% personnel file audit was completed to verify that all background clearance documentation corresponds to SBMC and meets statutory requirements. **System change:** The facility revised its pre-hire and file-verification checklist so that background clearance documentation must be validated for the correct legal entity/facility before the employee is cleared to work. **Monitoring:** The Administrator/designee will review all new personnel files prior to independent scheduling and will conduct a monthly audit of 5 personnel files for 6 months.	04/30/2026

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	-Employee #7 had a hire date of 04/07/2025, and a title of Caregiver. -Employee #8 had a hire date of 10/01/2024, and a title of Caregiver. -Employee #10 had a hire date of 07/07/2025, and a title of Caregiver. -Employee #11 had a hire date of 07/07/2025, and a title of Caregiver. On 11/10/2025 at 11:45 AM, the Administrator verbalized background checks were to be completed by the facility. The Administrator confirmed the clearance letters for employees #1, #2, #3, #5, #7, #8, #10, and #11 were for the wrong facility. Severity: 2 Scope: 3			
Y 0102 SS= D	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on personnel record review and interview, the facility failed to an ensure annual tuberculosis (TB) signs and symptoms or test was completed for 2 of 5 sampled employees due for annual TB testing (Employee #8 and #9), pursuant to Nevada Administrative Code, Chapter 441A. Findings include: Employee #8 Employee #8 was hired by the facility as a Caregiver on 10/01/2024. Employee #8's personnel record included a positive TB skin test completed on 09/11/2024 and a negative chest x-ray dated 09/16/2024. The record lacked documentation of an annual TB signs and symptoms screening completed for 2025. Employee #9	Y 0102	**Y0102 - Employee health / annual TB requirements** **Immediate correction:** Employee #8 received a current annual TB signs-and-symptoms review and Employee #9 received the required annual TB follow-up/testing per policy and regulatory requirements. Personnel files were updated. **How others were identified:** A 100% audit of all employees due for annual TB review/testing was completed and any missing items were obtained. **System change:** The facility added TB due dates to the annual compliance matrix and implemented reminder checkpoints before the due month and at the due date. **Monitoring:** The Administrator/designee will review the TB tracking log weekly for 4 weeks and monthly for 6 months.	04/30/2026

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	Employee #9 was hired by the facility as a Medication Technician on 08/01/2024. Employee #9's personnel record documented a negative QuantiFERON TB test dated 04/12/2024. The record lacked documentation of an annual TB test completed for 2025. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for TB testing. The Administrator confirmed Employee #8's personnel file lacked documented evidence of annual signs and symptoms completed and Employee #9 lacked an annual TB test. Severity: 2 Scope: 1			

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Y 0451 SS= F	**NAC 449.231 First aid and cardiopulmonary resuscitation.** 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure first aid kits contained Cardiopulmonary Resuscitation (CPR) shields. Findings include: On 11/11/2025, the first aid kits throughout the facility lacked CPR shields. On 11/11/2025 at 11:50 AM, the Wellness Director confirmed the facility's first aid kits lacked CPR shields. Severity: 2 Scope: 3	Y 0451	**Y0451 - First aid kits** **Immediate correction:** All first aid kits were immediately checked and stocked with CPR shields and any other missing required contents on 03/23/2026. **How others were identified:** A full-house audit of all first aid kits was completed to ensure each kit met required contents. **System change:** The facility implemented a monthly first-aid-kit checklist with assigned staff initials, manager verification, and replacement/ restock expectations. **Monitoring:** The Wellness Director/designee will audit all first aid kits weekly for 4 weeks, then monthly for 6 months.	04/30/2026
Y 0450 SS= D	**NAC 449.231** **First aid and cardiopulmonary resuscitation.**	Y 0450	**Y0450 - CPR and first aid training within 30 days** **Immediate correction:** Employee #7's CPR/first aid status was corrected and the file updated with current certification. The employee's status was reviewed for current safe assignment.	04/30/2026

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(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
	1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure the Administrator and caregivers received cardiopulmonary resuscitation (CPR) and first aid training within 30 days of employment for 1 of 11 sampled employees working at the facility greater than 30 days (Employee #7). Findings include: Employee #7 Employee #7 was hired by the facility as a Caregiver with a start date of 04/07/2025. Employee #7's employee file contained a training certificate dated 08/27/2025. The training was completed after the employee's 30 days of employment. On 11/10/2025 at 3:33 PM, the Administrator was unsure of the regulation requirements for CPR/First Aide training. The facility policy titled "Orientation and Training", undated, documented a learning coordinator would be assigned at each community to ensure annual training and state and federal required training were followed. All training would be sent, completed and documented through the facility platform. Severity: 2 Scope: 1		**How others were identified:** A 100% audit of all direct-care staff was completed to verify CPR/first aid completion within 30 days of hire and current certification status. **System change:** CPR/first aid was added to the onboarding hard-stop process. Employees will not be permitted to work beyond orientation or provide unsupervised care if the training has not been completed within the regulatory timeframe. **Monitoring:** The Administrator/designee will audit CPR/first aid due dates weekly for 4 weeks and monthly for 6 months.	
Y 0690 SS= F	**NAC 449.2712**	Y 0690		

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	Residents requiring use of oxygen. 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his need for oxygen; and (2) Administering the oxygen to himself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall;		**Y0690 - Residents requiring oxygen** **Immediate correction:** The two residents receiving oxygen were immediately reviewed by nursing/clinical leadership and the attending provider/appropriate practitioner to determine whether they remained appropriate for the facility's licensure level and whether current physician documentation, service planning, and resident capability requirements were met. Interim safety measures were implemented while the review was completed. **How others were identified:** A 100% review of all residents using oxygen was completed to confirm appropriateness for retention, current physician documentation, and service planning. **System change:** The facility implemented an admission/continued-stay clinical appropriateness review for oxygen. Any resident whose needs exceed licensure scope will be escalated immediately for provider review and discharge/transfer planning if needed. **Monitoring:** The Administrator and Wellness Director will review residents requiring oxygen weekly for 4 weeks and monthly for 6 months.	04/30/2026

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	(6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. 3. The administrator of a residential facility shall ensure that the caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident requiring the use of oxygen, was mentally and physically capable of operating the oxygen equipment for 2 of 2 residents requiring the use of oxygen. Findings include: On 11/11/2025, the following residents were administered oxygen and were not mentally and/or physically capable of operating the equipment that provided the oxygen and were not capable of determining the need for oxygen and administering the oxygen to themselves without assistance: On 11/11/2025 at 10:03 AM, in Room 105B, oxygen equipment was in the resident's room. On 11/11/2025 at 10:03 AM, the Activities Director/Business Office Manager verbalized the resident was not capable of determining the need for oxygen or managing the oxygen equipment. On 11/1/2025 at 10:45 AM, in Room 201B, oxygen equipment was in the resident's room.			

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	On 11/11/2025 at 10:45 AM, the Medication Technician (Med Tech) verbalized the resident was not capable of determining the need for oxygen or managing the oxygen equipment. The Med Tech verbalized the facility managed the resident's oxygen. Severity: 2 Scope: 3			
Y 0850 SS= E	**NAC 449.274 and R043-22** **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.** 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 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	Y 0850	**Y0850 - Annual physical examinations** **Immediate correction:** Residents #1, #9, #10, and #14 were reviewed and annual physical examinations were requested/obtained from the provider, with documentation filed in the clinical record as available. **How others were identified:** A 100% audit of all resident records was completed to identify missing annual physical examinations and any other overdue annual medical documents. **System change:** The facility created a resident annual-requirements tracker listing admission date, annual physical due date, annual assessment due dates, and responsible follow-up staff. The tracker is reviewed monthly. **Monitoring:** The Administrator/designee will audit the resident annual-requirements tracker weekly for 4 weeks and monthly for 6 months.	04/30/2026

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	which the illness was discovered; (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. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident.			

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	Inspector Comments: Based on clinical record review and interview, the facility failed to ensure physical examinations were completed annually for 4 of 15 sampled residents (Resident #1, #9, #10, and #14). Findings include: Resident#1 Resident#1 was admitted to the facility on 11/15/2023, with diagnoses including Parkinson, dementia and rhinitis. Resident#1's clinical record documented an annual physical exam, dated 12/31/2023. Resident #1's clinical record lacked documentation of an annual physical exam for 2024. Resident #9 Resident #9 was admitted to the facility on 05/01/2023, with diagnoses including dementia and hypertension. Resident #9's clinical record documented a physical examination dated 02/25/2024. The clinical record lacked documented evidence of an annual physical examination for 2025. On 11/10/2025 in the afternoon, the Administrator was unable to provide documentation of an annual physical examination completed in 2025 for Resident #9 as required. Resident #10 Resident #10 was admitted to the facility on 02/05/2024, with diagnoses including Alzheimer's disease and hypertension. Resident #10's clinical record documented			

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	an initial physical examination dated 01/31/2024. The clinical record lacked documented evidence of an annual physical examination for 2025. On 11/10/2025 in the afternoon, the Administrator was unable to provide documentation of an annual physical examination completed in 2025 for Resident #10 as required. Resident #14 Resident #14 was admitted to the facility on 10/04/2023, with diagnoses including dementia, hypertension, and hyperlipidemia. Resident #14's clinical record documented an initial physical examination completed on 10/17/2023 and lacked annual physical examinations completed for 2024 and 2025. On 11/10/2025 at 3:13 PM, the Administrator was unable to produce physical examinations completed in 2024 and 2025 for Resident #14 and confirmed the resident lacked physical examinations completed for 2024 and 2025. The Administrator explained all residents were required to have a physical examination completed upon admission to the facility and annually thereafter. Severity: 2 Scope: 2			
Y 0920 SS= F	**NAC 449.2748** **Medication Storage.** 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	Y 0920	**Y0920 - Medication storage** **Immediate correction:** Unsecured items found in resident rooms were removed or secured immediately unless specifically authorized and stored in a locked resident-specific container. The opened Latanoprost for Resident #5 was corrected to storage consistent with label/ manufacturer instructions and staff were re-educated.	04/30/2026

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	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 and interview, the facility failed to ensure 1) a resident's medications were stored in a secured area for 2 of 54 resident rooms in the secured facility and 2) a medication was stored according to manufacturer instructions for 1 of 15 sampled residents (Resident #5). Findings include: On 11/11/2025, the following rooms contained unsecured medications: - at 10:18 AM, in Room 112A * 33-ounce Pedialyte - at 1:26 PM, in Room 112B		**How others were identified:** A 100% sweep of resident rooms, medication carts/rooms, and medication refrigerators was completed to identify unsecured items and storage-condition errors. **System change:** The facility implemented a weekly medication-storage audit that includes resident room checks for unsecured medications, refrigerator audits, external-medication separation, and verification that opened medications follow manufacturer/pharmacy instructions. **Monitoring:** The Wellness Director/RCC or designee will complete weekly medication-storage audits for 8 weeks and monthly thereafter for 4 months.	

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	* Halls cough drops * Seven containers of Ensure On 11/11/2025 at 10:18 AM through 1:26 PM, the Wellness Director confirmed the medications were unsecured in the residents' rooms. Resident #5 Resident #5 was admitted to the facility on 09/26/2025, with diagnoses including severe dementia and hypertension. A Physician's Order dated 09/25/2025, documented Latanoprost ophthalmic solution 0.005 percent (%). Instill one drop in both eyes two times a day for eye health. On 11/10/2025 at 3:51 PM, during a review of Resident #5's medications and in the presence of a Medication Aide (MA) who was also identified as the Resident Care Coordinator (RCC), the MA/RCC retrieved a bottle of Latanoprost ophthalmic solution 0.005% eye drops from a refrigerator in the medication storage room. The pharmacy-prepared label on the box of eye drops included instructions to refrigerate until opened, then store at room temperature. The manufacturer insert documented to store unopened bottles under refrigeration, once opened may be stored at room temperature for eight weeks. On 11/10/2025 at approximately 3:55 PM, the MA/RCC acknowledged the pharmacy-prepared label and the manufacturer insert for the Latanoprost eyedrops indicated the bottle was to stored in the refrigerator until opened, then stored at room temperature. The MA/RCC confirmed the bottle had been opened and continued to be stored in the refrigerator. The MA/RCC verbalized facility staff had been told to always store eye drops in the refrigerator and confirmed storing the open bottle of Latanoprost eye drops in the refrigerator was not following the pharmacy's or manufacturer insert's instructions. The facility policy titled "Medications and			

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	Treatments –Medication Storage," undated, documented medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). Severity: 2 Scope: 3			
Y 0905 SS= D	**NAC 449.2746** **Administration of medication: Restriction concerning medication taken as needed by resident; written records.** 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his need for the medication; (b) The determination is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the amount of medication that may be given, and the frequency with which the medication may be given. 2. A caregiver who administers medication toa resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration;	Y 0905	**Y0905 - PRN medication documentation** **Immediate correction:** Resident #10's PRN orders/MAR were reviewed with the provider/ pharmacy and updated so the frequency, symptom-specific use, and administration instructions were clearly documented. **How others were identified:** A 100% audit of all PRN medications on all residents' MARs was completed to verify indication, dose, route, and frequency were present and matched active orders. **System change:** The facility implemented a PRN verification step in the order-entry and monthly MAR audit process. New PRN orders may not be filed as complete until the MAR reflects indication and frequency. **Monitoring:** The Wellness Director/RCC will audit all PRN orders weekly for 4 weeks and monthly for 6 months.	04/30/2026

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	(c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse. Inspector Comments: Based on observation, interview and clinical record review, the facility failed to ensure orders for As Needed (PRN) medications included the frequency at which the medications were to be administered for 1 of 15 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 02/05/2024, with diagnoses including Alzheimer's disease and hypertension. An Order Summary Report signed by the Physician on 10/30/2025, and Resident #10's November 2025 Medication Administration Record (MAR), documented the following orders: -Calcium Carbonate antacid oral tablet chewable 1000 milligrams (mg), give two tablets by mouth as needed for heartburn. -Cough drops mouth/throat lozenge, give one lozenge by mouth as needed for sore throat or cough. -Nystop external powder 100,000 Units/ Gram, apply to groin and buttock (gluteal fold) topically as needed for redness/irritation, apply quarter size amount. The Order Summary Report and the November 2025 MAR lacked a frequency at which the medications listed above were to be administered. On 11/10/2025 at 3:24 PM, during a review			

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	of Resident #10's medications the Medication Aide (MA) who was also identified as the Resident Care Coordinator (RCC) confirmed the resident's MAR lacked the frequency at which Calcium Carbonate antacid oral tablets, cough drops, and Nystop external powder were to be administered. The facility policy titled "Medications and Treatments -- PRN Medications," undated, documented staff were to check the frequency of the PRN medication if given in the previous 24 hours and whether it had been given the maximum number of times allowable for the day. Severity: 2 Scope: 1			
Y 0885 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to ensure a discontinued medication was destroyed for 1 of 15 sampled residents (Resident #10). Findings include:	Y 0885	**Y0885 - Destruction of discontinued medications** **Immediate correction:** The discontinued medication identified for Resident #10 was removed from active stock and destroyed/ disposed of according to policy with witness documentation, or otherwise secured pending pharmacy destruction per facility process. **How others were identified:** A 100% audit of all medication storage areas and resident-specific medications was completed to identify any discontinued, expired, or unclaimed medications requiring destruction or return. **System change:** The facility implemented a discontinued-medication destruction log with witness signature requirements and a reconciliation step whenever orders are discontinued, changed, or residents discharge. **Monitoring:** The Wellness Director/RCC will review the discontinued-medication log weekly for 4 weeks and monthly for 6 months.	04/30/2026

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	Resident #10 Resident #10 was admitted to the facility on 02/05/2024, with diagnoses including Alzheimer's disease and hypertension. On 11/10/2025 at 3:24 PM, during a review of Resident #10's medications and in the presence of Medication Aide (MA) who was also identified as the Resident Care Coordinator (RCC), a box of Imodium multi-symptom (Loperamide Hydrochloride 2 milligrams (mg)/ Simethicone 125 mg) with four tablets remaining in the box was provided for surveyor review. Resident #10's name was written on the box. Imodium, Loperamide, and Simethicone were not on Resident#10's Medication Administration Record (MAR). On 11/10/2025 at approximately 3:28 PM, the MA/RCC acknowledged Imodium, Loperamide, and Simethicone were not on Resident #10's MAR. The MA/RCC verbalized the MA/RCC was not sure why the medication was not on the MAR as the MA/RCC thought the medication was still ordered to be administered as needed. The MA/RCC confirmed if the medication was ordered by the physician, the medication should have been on the resident's MAR and if the medication had been discontinued, the medication should have been destroyed. On 11/10/2025 at approximately 4:45 PM, an Order Summary Report was located in Resident #10's record. The Order Summary Report was dated and signed by the physician on 04/16/2025, and included instructions to stop Loperamide. The facility policy titled "Medication and Treatments – Medication Release and Disposal," undated, documented medications would be properly disposed of when no longer prescribed. Severity: 2 Scope: 1			
Y 0878		Y 0878		

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SS= E	**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 (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		**Y0878 - Medication order / label / MAR reconciliation and medication availability** **Immediate correction:** Residents #10, #9, and #8 had their physician orders, MARs, pharmacy labels, and change stickers reviewed and corrected. Resident #5's active medications were reconciled with provider/pharmacy and ensured to be onsite and available for administration as ordered. **How others were identified:** A 100% medication reconciliation audit was completed for all residents comparing current physician orders, pharmacy labels, bubble packs/bottles, and MAR entries, including verification that active medications were physically available onsite. **System change:** The facility implemented a triple-check process for all new orders and order changes: provider order → MAR update → label/ package verification/change sticker → physical medication availability check. No order change is complete until all four steps are documented. **Monitoring:** The Wellness Director/RCC or designee will complete weekly med reconciliation audits for 8 weeks and monthly thereafter for 4 months.	04/30/2026

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	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, clinical record review, and interview, the facility failed to ensure a change label was affixed to a resident's medication container following a change in the prescriber's order for 3 of 15 sampled residents (Residents #10, #9, and #8) and medications were onsite and available to be administered as prescribed for 1 of 15 sampled residents (Resident #5). Findings include: Resident #10 Resident #10 was admitted to the facility on 02/05/2024, with diagnoses including Alzheimer's disease and hypertension. Resident #10's November 2025 Medication Administration Record (MAR) documented Furosemide oral tablet 20 milligrams (mg), give one tablet by mouth one time a day for hypertension. An Order Summary Report signed by the physician on 10/30/2025, documented Furosemide oral tablet 20 mg, give one tablet by mouth one time a day for hypertension. On 11/10/2025 at 3:24 PM, during a review of Resident #10's medications and in the presence of Medication Aide (MA), who was also identified as the Resident Care Coordinator (RCC), a bubble pack containing Furosemide 20 mg oral tablets was provided for surveyor review. The pharmacy-prepared label included instructions to take one tablet daily as needed for leg swelling. The MA/RCC			

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	confirmed the instructions on the label and the resident's MAR did not match and a change sticker should have been placed on the bubble pack. Resident # 9 Resident #9 was admitted to the facility on 05/01/2023, with diagnoses including dementia and hypertension. Resident #9's November 2025 MAR documented Atropine Sulfate Ophthalmic Solution 1%. Give one drop sublingually ever four hours as needed for excess secretions/spit. A physician's order dated 12/21/2025, documented Atropine Sulfate Ophthalmic Solution 1%. Give one drop sublingually ever four hours as needed for excess secretions/spit. On 11/10/2025 at 3:41 PM, the medication onsite documented, Atropine Sulfate Ophthalmic Solution 1%. Give one to two drops every four to six hours as needed for excess secretions. On 11/10/2025 at 3:41 PM, the MA/RCC confirmed the Atropine Sulfate Ophthalmic Solution has range on number of drops and frequence administration and the bottle lacked a change order sticker. Resident #8 Resident #8 was admitted to the facility on 06/29/2025, with diagnoses including degenerative disease of nervous system and dementia. An Order Summary Report dated 10/23/2025, documented the following physician's orders: -Senna oral tablet 8.6 mg, give one tablet by mouth one time a day for bowel regimen. -Senna oral tablet 8.6 mg, give one tablet by mouth every 12 hours as needed for constipation prevention. Hold for loose stool.			

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	On 11/10/2025 at 3:44 PM, during a review of Resident #8's medications and in the presence of the MA/RCC, a bubble pack containing Senna 8.6 mg tablets was provided for surveyor review. The pharmacy-prepared label included instructions to administer one tablet twice daily as needed for constipation. The MA/RCC was unable to locate an additional supply of Senna oral tablets and verbalized the bubble pack with instructions for PRN administration was used for both the daily scheduled dose and PRN administration. The MA/RCC explained a change sticker should have been placed on the bubble pack. Resident #5 Resident #5 was admitted to the facility on 09/26/2025, with diagnoses including severe dementia and hypertension. Resident #5's November 2025 MAR documented the following: -Lasix oral tablet 20 mg, give one tablet by mouth one time a day for edema. -Potassium oral tablet, give 10 mg by mouth one time a day for edema on Lasix. On 11/10/2025 at 3:51 PM, during a review of Resident #5's medications and in the presence of the MA/RCC, a bubble pack containing Potassium Chloride 20 milliequivalents (meq) with instructions to take one tablet by mouth daily was provided for surveyor review. The MA/RCC acknowledged the medication did not match the resident's MAR. The MA/RCC was unable to locate a supply of Lasix 20 mg and Potassium 10 mg. The MA/RCC acknowledged the medications were on the resident's MAR and confirmed the medications were not readily available for administration. The facility policy titled "Medications and Treatments – Medication Services," undated, documented qualified staff would assist residents to make sure medications were ordered and available as needed. Guidelines for staff administering			

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	medications included reading the medication label and comparing the label to the MAR to assure both matched including the resident's name, the medication, dose, time, and route. Severity: 2 Scope: 2			
Y 0930 SS= D	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he 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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special	Y 0930	**Y0930 - Resident file contents / admission TB / ADL timing** **Immediate correction:** Residents #5, #13, and #7 were reviewed for admission TB compliance and missing documentation was obtained or follow-up testing arranged per regulation. Resident #7's ADL assessment was reviewed and updated in the record. **How others were identified:** A 100% audit of all resident files was completed for admission TB requirements, annual TB requirements, admission assessments, annual ADL evaluations, physician statements, and other required resident-file elements. **System change:** The facility implemented a resident admission hard-stop checklist requiring TB compliance, admission assessment, ADL assessment, physician documentation, and file completeness before the admission file is considered closed. A separate annual chart-audit tool was also implemented. **Monitoring:** The Administrator/designee will audit all new admissions weekly for 8 weeks and audit 5 resident records monthly for 6 months.	04/30/2026

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	diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident;			

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	(2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i)The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death.			

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	3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on clinical record review and interview, the facility failed 1) to ensure 3 of 15 sampled residents (Resident #5, #13, and #7) met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A and 2) to ensure an initial Activities of Daily Living (ADL) Assessment was completed timely for 1 of 15 sampled residents (Resident #7). Findings include: Resident #5 Resident #5 was admitted to the facility on 09/26/2025, with diagnoses including severe dementia and hypertension. Resident #5's clinical record documented a TB one step skin test was administered on 08/26/2025, and the result was negative. The clinical record lacked the date and time the test was read and lacked documented evidence of the completion of a second step TB skin test. On 11/10/2025 in the afternoon, the Administrator verbalized the Administrator had located documentation of the first step TB skin test (as described above) for Resident #5 and attempted to locate documentation of a second step as two steps were required upon admission per regulation.			

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	The Administrator failed to provide documented evidence of a completed two-step TB skin test for Resident #5 prior to the end of survey. Resident #13 Resident #13 was admitted to the facility on 05/31/2025, with diagnoses including dementia. Resident #13's clinical record documented the date of initial 2-step purified protein derivative (PPD) or chest X-Ray for TB was on 04/30/2025, and the result was negative. The document lacked the date and time the test was read and lacked documented evidence of the completion of a second step TB skin test. The Administrator failed to provide documented evidence of a completed two-step TB skin test for Resident #13 prior to the end of survey. Resident #7 Resident #7 was admitted to the facility on 09/17/2025, with diagnoses including unspecified cognitive impairment, hypertension, and hypothyroidism. Resident #7's clinical record documented an initial one-step TB test administered on 09/13/2025, and read negative on 09/16/2025. A second step for TB could not be located. On 11/10/2025 at 3:33 AM, the Administrator confirmed Resident #7 only received a one-step TB test upon admission to the facility and a previous TB test was not obtained. The Administrator verbalized all residents were required to complete a two-step TB test upon admission to the facility and a one-step TB test annually thereafter. Resident #7's clinical record documented an initial ADL Assessment completed on 09/19/2025, two days after admission to the facility. On 11/10/2025 at 3:34 PM, the			

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	Administrator confirmed Resident #7's initial ADL Assessment was completed late and verbalized all residents were required to have an ADL Assessment completed upon admission to the facility and annually thereafter. Severity: 2 Scope: 1			

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Y 0994 SS= F	**NAC 449.2756** **Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required;** (e) Knives, matches, firearms, tools, and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to 41 of 41 residents in the facility. Findings include: On 11/11/2025 at 10:26 AM, in the Activities Room, an unlocked cabinet contained the following items: - Sixteen bottles of nail polish - Clorox disinfecting wipes The facility policy and procedure adopted February 2019 and reviewed May 2024, specified, "All hazardous or toxic substances are stored in a locked area and are not accessible to the residents. These include personal care items (examples include shampoos, toothpaste, make-up etc.) and environmental cleaning products that if ingested could be harmful). On 11/11/2025 between 10:01 AM and 10:35 AM, the Wellness Director confirmed the above-mentioned items could be toxic to residents in a memory care facility. Severity: 2 Scope: 3	Y 0994	**Y0994 - Toxic substances inaccessible** **Immediate correction:** The unlocked toxic/ potentially harmful items in the Activities Room were immediately removed to locked storage on 03/23/2026, and all other accessible areas were checked for similar items. **How others were identified:** A full facility environmental safety sweep was completed to identify toxic substances, sharps, tools, and other potentially dangerous items accessible to residents. **System change:** The facility implemented a daily environmental safety round for line staff and a weekly manager round for validation. Activities and personal-care supplies with ingestion/ toxicity risk must be stored in locked areas at all times. **Monitoring:** The Wellness Director/ Administrator will review the environmental round logs weekly for 8 weeks and monthly for 4 months.	04/30/2026
Y 1035 SS= F		Y 1035		

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	NAC 449.2768 **Residential facility which provides care to persons with Alzheimer's disease: Alzheimer's/dementia Training:** 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this		**Y1035 – Dementia training** **Immediate correction:** The employees identified as missing the 2-hour within-40-hours training, the 8-hour within-90-days training, and the 3-hour anniversary training were scheduled/completed as applicable and personnel files were updated. **How others were identified:** A 100% audit of all staff with direct contact with residents with dementia was completed to verify the 40-hour, 90-day, and annual dementia-training requirements. **System change:** The facility added all three dementia-training milestones to the onboarding and annual compliance matrix. New staff may not progress through orientation without the initial dementia requirement, and anniversary alerts are now tracked by hire date. **Monitoring:** The Administrator/designee will audit dementia-training compliance weekly for 4 weeks and monthly for 6 months.	

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	subparagraph are in addition to those set forth in subparagraphs (1) and (2). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 6 of 11 sampled employees received two hours of dementia training within the first 40 hours of employment (Employee #2, #3, #4, #7, #10, and #11), 2 of 11 sampled employees received at least eight hours of dementia training within three months of hire (Employee #7 and #11) and 4 of 11 sampled employees completed the required minimum of three hours of training in providing care to a resident with dementia by the hire anniversary date (Employee #5, #6, #8 and #9). Findings include: Two Hours Dementia Training within 40 Hours of Employment Employee #2 Employee #2 was hired by the facility as a Health Services Director with a start date of 11/03/2025. Employee #2's personnel file lacked documented evidence of two hours of dementia training within the first 40 hours of employment. Employee #3 Employee #3 was hired by the facility as a			

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	8640	A. BUILDING _____ B. WING _____	11/10/2025

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	Caregiver with a start date of 07/07/2025. Employee #3's personnel file lacked documented evidence of two hours of dementia training within the first 40 hours of employment. Employee #4 Employee #4 was hired by the facility as a Caregiver with a start date of 05/08/2025. Employee #4's personnel file lacked documented evidence of two hours of dementia training within the first 40 hours of employment. Employee #7 Employee #7 was hired by the facility as a Health Services Director with a start date of 04/07/2025. Employee #7's personnel file lacked documented evidence of two hours of dementia training within the first 40 hours of employment. Employee #10 Employee #10 was hired by the facility as a Caregiver with a start date of 07/07/2025. Employee #10's personnel file lacked documented evidence of two hours of dementia training within the first 40 hours of employment. Employee #11 Employee #11 was hired by the facility as a Caregiver with a start date of 07/07/2025. Employee #11's personnel file lacked documented evidence of two hours of dementia training within the first 40 hours of employment. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for initial two hour of dementia training within 40 hours of employment. The Administrator explained the training records			

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	provided were what was available. Eight Hours of Dementia Training in 90 Days Employee #7 Employee #7 was hired by the facility as a Caregiver with a start date of 04/07/2025. Employee #7's personnel file contained the required eight hours of dementia training completed 10/14/2025; however, was completed after the first 90 days of hire. Employee #11 Employee #11 was hired by the facility as a Caregiver with a start date of 07/07/2025. Employee #11's personnel file lacked documented evidence of the required eight hours of dementia training within 90 days of hire. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for eight hours dementia training within the first 90 days of employment. The Administrator explained the training records provided were what was available. Three Hours of Dementia Training by Hire Anniversary Date Employee #5 Employee #5 was hired by the facility as a Medication Technician with a start date of 08/01/2024. Employee #5's personnel record lacked documented evidence of three hours of annual dementia training completed by 08/01/2025. Employee #6 Employee #6 was hired by the facility as a Caregiver with a start date of 08/01/2024. Employee #6's personnel record lacked			

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	documented evidence of three hours of annual dementia training completed by 08/01/2025. Employee #8 Employee #8 was hired by the facility as a Caregiver with a start date of 10/01/2024. Employee #8's personnel record lacked documented evidence of three hours of annual dementia training completed by 10/01/2025. Employee #9 Employee #9 was hired by the facility as a Medication Technician with a start date of 08/01/2024. Employee #9's personnel record lacked documented evidence of three hours of annual dementia training completed by 08/01/2025. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for the annual three of dementia training. The Administrator explained the training records provided were what was available. The facility policy titled "Orientation and Training", undated, documented a learning coordinator would be assigned at each community to ensure annual training and state and federal required training were followed. All training would be sent, completed and documented through the facility platform. Severity: 2 Scope: 3			
Y 1840 SS= E	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization	Y 1840	**Y1840 - Infection control and prevention training** **Immediate correction:** Employees #5, #6, #8, and #9 were scheduled/completed for the required infection-control training and documentation was filed.	04/30/2026

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	concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure an unlicensed caregiver completed infection control and prevention training for 4 of 11 employees (Employee #5, #6, #8, and #9). Findings include: Employee #5 Employee #5 was hired as a Medication Technician on 08/01/2024. Employee #5's personnel record lacked documented evidence the employee had completed infection control and prevention training. Employee #6 Employee #6 was hired as a Caregiver on 08/01/2024. Employee #6's personnel record lacked documented evidence the employee had completed infection control and prevention training. Employee #8		**How others were identified:** A 100% audit of unlicensed caregivers was completed to verify annual infection-control training completion. **System change:** Annual infection-control education was added to the compliance matrix with due-date reminders and file-validation steps. **Monitoring:** The Administrator/designee will audit infection-control training compliance weekly for 4 weeks and monthly for 6 months.	

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	Employee #8 was hired as a Caregiver on 10/01/2024. Employee #8's personnel record lacked documented evidence the employee had completed infection control and prevention training. Employee #9 Employee #9 was hired as a Medication Technician on 08/01/2024. Employee #9's personnel record lacked documented evidence the employee had completed infection control and prevention training. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for unlicensed caregiver training. The Administrator explained the training records provided were what was available. The facility policy titled "Orientation and Training", undated, documented a learning coordinator would be assigned at each community to ensure annual training and state and federal required training were followed. All training would be sent, completed and documented through the facility platform. Severity: 2 Scope: 2			
Y 1540 SS= E	**NAC 449.011931and R004-24** NAC 449.011931 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described	Y 1540	**Y1540 - Cultural competency training** **Immediate correction:** Employees #1, #7, #8, and #10 were reviewed and scheduled/ completed for cultural competency training, with documentation placed in the personnel files. **How others were identified:** A 100% audit of all employees subject to the cultural competency requirement was completed to identify any missing or untimely training.	04/30/2026

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	in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal.		**System change:** Cultural competency training was added to the 90-day onboarding checklist and biennial tracking system, including documentation of exemption status for licensed staff when applicable. **Monitoring:** The Administrator/designee will audit cultural competency compliance weekly for 4 weeks and monthly for 6 months.	

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	Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 4 of 11 sampled employees required to obtain cultural competency training (Employee #1, #7, #8 and #10). Findings include: Employee #1 Employee #1 was hired by the facility as the Administrator with a hire date of 10/08/2024. Employee #1's personnel file lacked documented evidence of Cultural Competency training completed within 90 days of hire. Employee #7 Employee #7 was hired by the facility as a Caregiver with a hire date of 04/07/2025. Employee #7's personnel file lacked documented evidence of Cultural Competency training completed within 90 days of hire. Employee #8 Employee #8 was hired by the facility as a Caregiver with a hire date of 10/01/2024. Employee #8's personnel file lacked documented evidence of Cultural Competency training completed within 90 days of hire. Employee #10 Employee #10 was hired by the facility as a Caregiver with a hire date of 07/07/2025. Employee #10's personnel file lacked documented evidence of Cultural Competency training completed within 90 days of hire. On 11/10/2025 at 3:33 PM, the Administrator was unaware of the regulation requirements for cultural competency			

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	training. The Administrator explained the training records provided were what was available. The facility policy titled "Orientation and Training", undated, documented a learning coordinator would be assigned at each community to ensure annual training and state and federal required training were followed. All training would be sent, completed and documented through the facility platform. Severity: 2 Scope: 2			