DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**06/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRATIONS SENIOR LIVING IN PAHRUMP	**931 EAST HONEYSUCKLE ST, PAHRUMP, NEVADA ,89048**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted at your facility on 06/03/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 78 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was 68. 15 resident files and eight employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated: Complaint #NV00073037 was substantiated, see TAG 878. The investigation of the complaint included: Observations were made of the Memory Care resident rooms, medication rooms and storage. Observed staff interaction with the Resident of Concern, other residents in the Memory Care during mid-day medication pass and after lunch activities. Interviews were conducted with Resident of Concern, Resident of Concern's roommate, other residents in the Memory Care. Staff interviews were conducted with Caregivers, Medication Technicians and the Administrator. Clinical Record Review of three resident records included the Resident of Concern's record. Document Review included facility policy and procedures, incident logs, pharmacy reviews and resident medication administration records. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	0000		
0878	Medication/OTCS, Supplements, Change	0878	We will provide an Inservice for	08/12/202

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: DANIELLE JURANTY Title: Administrator Date: 08/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SS= D	Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 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		the Med Techs where they are educated on the Physicians Notification of missed medications form. The Inservice will provide training to complete and retain documentation where the provider was notified when a resident does not receive their medications, as well as the documentation where we follow-up with the physician. Wellness Director to ensure that within 5 days of any new or changed medication orders, that the order is to be profiled and included in the residents EMAR. Wellness director to audit all new or changed medication orders weekly to ensure compliance.	5

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	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 administered in accordance with physicians' orders for 1 of 15 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 06/12/23 with diagnosis including Alzheimer's Disease, Dementia and Unsteady Gait. A Physician's order dated 07/07/23, documented Folic Acid 1 MG tablet, take one tab by mouth every day. The November 2024 Medication Administration Record (MAR) documented R4 did not receive Folic Acid on 11/20/24, 11/21/24, 11/22/224, 11/23/24, 11/24/24, 11/25/24 and 11/26/24. A physician's order dated 07/07/23 documented Memantine HCL F/C 5MG tablet, take 1 tab by mouth twice daily for dementia. The November 2024 MAR documented R4 did not receive the PM dose of Memantine HCL on 11/19/25, 11/24/24 and 11/25/25. R4 also did not receive the AM dose on 11/20/24, 11/21/24, 11/22/24, 11/23/24, 11/24/24, 11/25/24 and 11/26/24. A physician's order dated 07/07/23, documented Risperidone F/C 0.25MG tablet, take 1 tab by mouth twice daily for dementia. The November 2024 MAR documented R4 did not receive their AM dose of Risperidone on 11/18/25, 11/19/25, 11/20/25, 11/21/25, 11/22/24, 11/23/24, 11/24/24, 11/25/25 and 11/26/25. R4 also did not receive the PM dose on 11/20/24, 11/21/24, 11/22/24, 11/23/24, 11/24/24 and 11/25/24. A Physician's order dated 09/20/23, documented Quetiapine Fumarate 50MG tablet, take 1 tab by mouth twice daily. The November 2024 MAR documented R4 did not receive their AM			

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	dose of Quetiapine Fumarate on 11/24/24, 11/25/25 and 11/26/25. R4 also did not receive the PM dose on 11/19/24, 11/24/24 and 11/25/24. A physician's order dated 10/12/23, documented Sertraline HCL 25MG tablet, take 1 tab by mouth every day. The November 2024 MAR documented R4 did not receive Sertraline on 11/18/24, 11/19/24, 11/20/24, 11/21/24, 11/22/24, 11/23/24, 11/24/24, 11/25/24 and 11/26/24. On 06/03/2025 in the afternoon, the Administrator acknowledged R4 missed their required routine medications on 11/18/25, 11/19/25, 11/20/25, 11/21/25, 11/22/24, 11/23/24, 11/24/24, 11/25/25 and 11/26/25 and the medications were not administered per the physician's orders. On 06/03/25 in the afternoon, the Administrator indicated the family member designated as R4's Power of Attorney (POA) refused to sign the Pharmacy Agreement for services. The medications would not be refilled by the pharmacy without the POA's signature which led to the missed medications on 11/18/25, 11/19/25, 11/20/25, 11/21/25, 11/22/24, 11/23/24, 11/24/24, 11/25/25 and 11/26/25. The Administrator acknowledged the missing medication dates for R4. On 06/03/2025 in the afternoon, the Administrator indicated the facility did not have a written policy and procedure to address this type of situation. The facility's policy and procedure titled Physician Notification of Missed Medication documented: Physician must be notified within 12 hours after the dose was refused or missed. The facility developed a missed medication form, (developed and implemented on 04/26/2018). The Med Tech on duty was noted as the responsible staff member who was to notify the physician when their patient who resides in the facility missed a medication. The Med Tech must document the reason(s) the medication(s) were missed. Although the facility notified the physician, the facility lacked documented evidence they had followed-up with the physician regarding the			

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	missed medications. Severity: 2 Scope: 1			