STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10953	A. BUILDING _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSET RENO MEMORY CARE	6205 SHARLANDS AVE, RENO, NEVADA ,89523

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed at your facility on 09/17/2025. The facility is licensed for 103 Residential Facility for Groups beds with assisted living services for elderly or disabled persons and/or persons with mental illness and/or persons with Alzheimer's disease, 55 Category II Alzheimer's residents and 48 Category II non-Alzheimer's residents. The census at the time of the survey was 51. 15 resident records and 10 employee records were reviewed. The facility received a grade of D.			
Y 0051 SS= C	**NAC 449.194** 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be	Y 0051	Y 051 When completing your Plan of Correction, you must address all of the following: 1) Administrator designee sheet was posted immediately 2) Administrator's designee sheet will not be removed and replaced after it's been updated 3) Visually rounds of board will be done Monthly for 3 months to ensure posting is not removed 4)	02/21/2026

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	posted in a public place within the facility during all times that the employee is in charge. Inspector Comments: Based on observation and interview, the facility failed to post the name of the administrator and the Administrator's designee in a public place. Findings include: On 09/17/2025 at 8:09 AM, the name of the administrator and the Administrator's designee were not posted in the facility. On 09/17/2025 at 8:09 AM, the Administrator verbalized the posting had been removed for updating the information and not been replaced. Severity: 1 Scope: 3		Business manger 5) The date 3/28/2026 6) You must attach all supporting documents into the system (MUST INCLUDE). Attached document 7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) monthly audit will be reviewed quarterly to ensure compliance	

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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 file review, document review and interview, the facility failed to ensure tuberculosis (TB) screening was completed in accordance with Nevada Administrative Code 441A.375 for 1 of 10 sampled employees (Employee #5). Findings include: On 09/17/2025 at 10:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 10 sampled employees. On 09/17/2025 at 2:30 PM, the Business Office Manager provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as a Medication Technician (Med Tech) with a start date of 05/07/2024. Employee #5's personnel file documented a negative QuantiFERON test dated 11/15/2023. Employee #5's personnel file lacked documented evidence of a TB test for 2024 or 2025. On 09/17/2025 at 2:30 PM, the Business Office Manager confirmed Employee #5's personnel file lacked documented evidence of TB testing for Employee #5. Severity: 2 Scope: 1	Y 0102	102 When completing your Plan of Correctionyou must address all of the following: 1) Employee # 5 no longer here 2) All employees being referred to go do annually TB test will be taken off schedule 10 days prior to expiring for non-compliance 3) Tracking sheet created for staff 4) Businessoffice manger 5) The date the corrective action will becompleted (MUST INCLUDE); AND 3/28/2025 6) You must attach all supporting documents intothe system (MUST INCLUDE). Tracking sheet attached 7) Monthly review of log and quarterly for compliance	02/21/2026
Y 0104		Y 0104		02/21/202

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SS= E	**NAC 449.200** **Personnel files** (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on personnel file review, document review and interview, the Administrator failed to ensure 3 of 10 sampled employees met the background check requirements of Nevada Revised Statute (NRS) 449.122 to 449.125 (Employee #5, #6, and #7). Findings include: On 09/17/2025 at 10:00 AM, the Business Office Manager was provided with the Personnel Check List to complete for 10 sampled employees. On 09/17/2025 at 2:30 PM, the Business Office Manager provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as a Medication Technician (Med Tech) with a start date of 05/07/2024. Employee#5's personnel file lacked documented evidence the employee's fingerprints were taken. Employee #6 Employee # 6 was hired by the facility as a Med Tech with a start date of 07/16/2024. Employee #6's personnel file documented the employee's fingerprints were taken on 08/13/2024, 25 days after the date of hire. Employee #7		104 When completing your Plan of Correction you must address all of the following: 1) Employee #5 no longer here Employee #6 No longer here Employee #7 paperwork was in file. 2) Employee #7 Nabs paperwork is dated 11/25/2024as date of hire and cleared 11/25/2024 in fingerprints system. We are sending employees for fingerprint prior to hire date. 3) We will be using a tracking sheet 4) Business office to maintenance tracking sheet 5) The date the corrective action will be completed (MUST INCLUDE); AND 3/28/2026 6) You must attach all supporting documents into the system (MUST INCLUDE). See attached log 7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) Log to be reviewed monthly and report will be reviewed on a quarterly basis	6

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	Employee #7 was hired by the facility as a Med Tech with a start date of 11/25/2024. Employee#7's personnel file lacked documented evidence the employee's fingerprints were taken. On 09/17/2025 at 2:30 PM, the Business Office Manager confirmed Employees #5, #6, and #7 had not completed the required background check timely. Severity: 2 Scope: 2			
Y 0172 SS= D	**NAC 449.209** 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors;	Y 0172	172 When completing your Plan of Correctionyou must address all of the following: 1) Lid was closed 2) Maintenance checking daily 3) Log will be used to track closure of trash lids 4) Maintenance director 5) 3/28/2026 6) Log attached 7) Log will be review monthly and assess quarterly	02/21/2026

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	(b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. Theadministrator of a residential facility shall ensure that the premises areclean and that the interior, exterior and landscaping of the facility are wellmaintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the outside garbage receptacles were sealed (lid closed). This deficient practice had the potential to result in odor permeation and pest attraction. Findings include: On 09/17/2025 at 8:42 AM, an outside garbage receptacle was open with the lid at the back side of the receptacle. On 09/17/2025 at 8:43 AM, the Culinary Director confirmed the receptacle was open. The Culinary Director verbalized the facility usually kept the garbage receptacle open during the day and closed during the night; however, the Culinary Director explained the receptacle should never be open due to the risk of rain or snow, odors, and pests. Severity: 2 Scope: 1			

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Y 0450 SS= D	**NAC 449.231** **First aid and cardiopulmonary resuscitation.** 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, document review and interview, the Administrator failed to ensure 1 of 10 sampled employees completed First Aid and cardiopulmonary resuscitation training within 30 days of hire (Employee #7). Findings include: Employee #7 was hired by the facility as a Med Tech with a start date of 11/25/2024. Employee #7's personnel file documented the employee completed First Aid and CPR training on 08/09/2025, over 7 months after date of hire. On 09/17/2025 at 2:30 PM, the Business Office Manager confirmed the documentation for first aid/CPR training was not completed timely for Employees #7. Severity: 2 Scope: 1	Y 0450	450 1) Employee #7 was resent for new card 2) Business office to obtain upon hire or schedule within 30 days of hire 3) CPR will be added to the tracking log 4) Business office 5) 3/28/2026 6) Log attached 7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) log reviewed monthly and adjusted quarterly for review	02/21/2026
Y 0451 SS= F	**NAC 449.231 First aid and cardiopulmonary resuscitation.**	Y 0451	451 When completing your Plan of	02/21/2026

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	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 maintain the contents of 4 of 4 first aid kits. Findings include: On 09/17/2025, a review of the facility's first aid supplies revealed the following: Second Floor Medication Room: The first aid kit lacked a CPR mask, germicide, and a thermometer or fever strips. Second Floor Kitchen: The first aid kit lacked adhesive bandages and a thermometer or fever strips. First Floor Medication Room: the first aid kit lacked roller gauze, germicide and a thermometer or fever strips. First Floor Kitchen: the first aid kit lacked a thermometer or fever strips.		Correction,you must address all of the following: 1) New first aid kits were purchased 2) First aids Kits to be checked monthly 3) Log created to check first aid kits 4) Maintenance director 5) 3/28/2026 6) Log attached 7) Monthly log will be reviewed on a quarterly basis	

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	On 09/17/2025 the Maintenance Director was present at each discovery and confirmed the first aid kits were missing required items. Severity: 2 Scope: 3			
Y 0515 SS= F	**NAC 449.259** **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other	Y 0515	515 When completing your Plan of Correction,you must address all of the following: 1) we moved to a new program that has service plans and care plans separate for printing. New plans printed for residents #. 6,10,12,13,14,15 resident # 8,9,11 no longer in the facility 2) New program allows for service plans to be printed 3) Upon admission and annually and as updated 4) Resident care director and memory care director 5) 3/28/2026 6) Service plan attached 7) updated service plan will be review monthly and quarterly	02/21/2026

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	arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review, document review and interview, the facility failed to develop complete person-centered service plans for 9 of 15 sampled residents requiring assisted living services (Resident #6, #8, #9, #10, #11, #12, #13, #14, and #15). Findings include: Resident #6 Resident #6 was admitted to the facility on 07/02/2025, with diagnoses including memory impairment and arthritis. Resident #8 Resident #8 was admitted to the facility on 02/28/2025, with diagnoses including dementia and cerebrovascular accident. Resident #9 Resident #9 was admitted to the facility on 08/29/2024, with diagnoses including dementia, chronic obstructive pulmonary disorder, and schizophrenia. Resident #10 Resident #10 was admitted to the facility on 06/04/2025, with a diagnosis of Alzheimer's disease.			

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	Resident #11 Resident #11 was admitted to the facility on 09/11/2025, with diagnoses including diabetes mellitus type two and dementia. Resident #12 Resident #12 was admitted to the facility on 11/05/2024, with diagnoses including visual loss, dementia, and Crohn's disease. Resident #13 Resident #13 was admitted to the facility on 08/02/2024, with diagnoses including chronic obstructive pulmonary disease and emphysema. Resident #14 Resident #14 was admitted to the facility on 01/30/2025, with a diagnosis of dyspnea. Resident #15 Resident #15 was admitted to the facility on 08/30/2024, with a diagnosis of Parkinson's disease, cerebral ischemia and altered mental status. On 09/17/2025 at 11:50 AM, the Resident Services Director confirmed the facility had not completed person-centered service plans for 9 of 15 sampled residents and verbalized having understood the Activities of Daily Living assessments were the only regulation requirement. The Resident Services Director verbalized having been responsible for the completion of the service plans. The facility policy titled, "Service Plans," undated, documented resident centered service plans were to be created and maintained for every resident as to provide services based on individual needs, abilities, and preferences. Severity: 2 Scope: 3			
Y 0522		Y 0522		02/21/202

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SS= F	NAC 449.259 (k) If the resident has Alzheimer's disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility, including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if: (I) It is determined through an assessment conducted pursuant to paragraph (c) of subsection 1 of NRS 449.1845 that the resident meets the criteria prescribed in paragraph (a) of subsection 2 of that section; and (II) The facility does not meet the requirements of NAC 449.2754 or 449.2756 or is otherwise unable to properly care for the resident. Inspector Comments: Based on record review, document review and interview, the facility failed to develop complete person-centered service plans for 6 of 15 sampled residents requiring memory care services (Resident #1, #2, #3, #4, #5, and #7). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/15/2025, with diagnoses including type two diabetes mellitus and Alzheimer's dementia. Resident #2 Resident #2 was admitted to the facility on 08/04/2025, with diagnoses including cellulitis, hypothyroidism, encephalopathy, and amnesia. Resident #3		522 When completing your Plan of Correction,you must address all of the following: 1) We have a new system that can print services plan separately. Service plans printed resident #1,2,4, 5,7 Resident #3 no longer in facility 2) New system allows for person centered serviceplans to print 3) All service care plans will be done upon admission and annually and as updated 4) Resident care director and memory care director 5) 3/28/2026 6) Service plan sample attached 7) updated service plan will be review monthly and quarterly	6

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	Resident #3 was admitted to the facility on 04/27/2024, with a diagnosis of Alzheimer's disease. Resident #4 Resident #4 was admitted to the facility on 01/23/2024, with diagnoses including Alzheimer's Disease and dementia. Resident #5 Resident #5 was admitted to the facility on 03/28/2024, with diagnoses including cognitive impairment and atrial fibrillation. Resident #7 Resident #7 was admitted to the facility on 02/25/2025, with diagnoses including cognitive impairment and dementia. On 09/17/2025 at 11:50 AM, the Resident Services Director confirmed the facility had not completed person-centered service plans for memory care residents and verbalized having understood the Activities of Daily Living assessments were the only regulation requirement. The Resident Services Director verbalized having been responsible for the completion of the service plans. The facility policy titled, "Service Plans," undated, documented resident centered service plans were to be created and maintained for every resident as to provide services based on individual needs, abilities, and preferences. Severity: 2 Scope: 3			
Y 0690 SS= E	**NAC 449.2712** **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	Y 0690	690 -1 When completing your Plan of Correctionyou must address all of the following: 1) B size tank was put in holder and full B tank was put in wheelchair holder	02/21/2026

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	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; (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		2) Contacted oxygen company to not leave more tanks than the rack could hold Maintenance will be notify of deliveries to leave more than the racks can hold 3) Dailyround of oxygen tanks to be put in racks. 4) Maintenance Director 5) 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). Log for oxygen tanks in rooms 7) How you will identify and correct other areashaving potential to be affected by the same deficient practice (if applicable) log will be review monthly and quarterly 690 -2 1) Oxygen concentrator removed immediately, Hospice discontinued the prn oxygen order 2) No resident in memory care will have a prn order 3) All orders for oxygen will be reviewed for memory care resident prior to Administration and review with doctor. 4) Resident care and or memory care	

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	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 record review, observation, interview, and document review, the facility failed to ensure 1 of 6 rooms with oxygen tanks had the tanks secured in a stand or to the wall, and failed ensure a resident, requiring the use of oxygen, was mentally and physically capable of operating the oxygen equipment for 1 of 15 sampled residents (Resident #4). Findings include: Room 123 - At 12:06 PM, the room had one e-size tank standing unsecured on the floor in the living room. Across the room, two racks were in place, one with 10 e-size tanks and one with 12 b-size tanks. An additional (13th) b-size tank was standing unsecured on the floor next to the rack. On 09/17/2025, the Maintenance		director 5) 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). log 7) How you will identify and correct other areashaving potential to be affected by the same deficient practice (if applicable) Any new orders will be put log and brought to monthly meeting and reviewed quarterly	

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	Director confirmed the oxygen tanks were not secured and verbalized oxygen tanks should be kept secured. Resident #4 Resident #4 was admitted to the facility on 01/23/2024 with diagnoses including Alzheimer's Disease and dementia. A physician's order for oxygen dated 09/17/2025, documented 2 liters per minute (LPM), via nasal cannula, as needed for comfort and ease of breathing. On 09/17/2025 at 2:32 PM, an oxygen concentrator was located next to Resident #4's bed. The concentrator was not on. On 09/17/2025 at 2:34 PM, Resident #4 was sitting in a reclining chair in the common area. The resident was not wearing a nasal cannula or using any oxygen device. The resident did not respond to questions and did not speak during the interview. On 09/17/2025 at 2:38 PM, the Caregiver verbalized having seen Resident #4 use the oxygen while in bed the night before. The Caregiver verbalized the resident could not operate			

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	the concentrator on their own due to the resident's condition. On 09/17/2025 at 2:41 PM, the Medication Technician (Med Tech) confirmed Resident #4 had an oxygen concentrator due to the resident's decline. The Med Tech verbalized the concentrator had been brought in by hospice a few days prior and the staff would place the nasal cannula on the resident and turn on the concentrator for the resident. The Med Tech verbalized the Resident #4 would not have been able to manage the concentrator or their own oxygen. The Med Tech was unsure how much oxygen the resident needed and when and verbalized having to obtain clarification with hospice. On 09/17/2025 at 3:36 PM, the Resident Services Director verbalized not having been aware residents requiring the use of oxygen could not be placed in the facility unless the resident could operate and manage their own oxygen. On 09/17/2025 at 3:38 PM, the Executive Director confirmed Resident #4 was not able to manage their own oxygen. The facility policy titled,			

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	"Allowable Health Conditions," undated, documented the facility would admit stable residents with conditions that can be safety cared for and resident's requiring oxygen must have the capability to self-administer their own oxygen. Severity: 2 Scope: 2			
Y 0773 SS= F	NAC 449.2726 **Resident having diabetes.** 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident's glucose testing is performed by: (1) The resident himself or herself without assistance; or (2) With the consent of the resident, a caregiver who meets the requirements of NAC 449.196; and 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (b) The resident's medication is administered: (1) By the resident himself or herself without assistance;	Y 0773	773 1) Med tech access to check off insulinand note as per nurse given removed Resident 1 still in facility being managed by 3rdparty Resident 11 no longer in facility 2) Any resident requiring diabetic managementwill be serviced by outside 3rd party for diabetic management 3) 3rdparty will keep MAR of resident being managed by their service and will be reviewed with facility 4) Executive director and resident care director 5) The date the corrective action will be completed (MUST INCLUDE); AND 3/28/2026 6) You must attach all supporting documents intothe system (MUST	02/21/2026

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	(2) By a medical professional, or licensed practical nurse, who is: (I) Acting within his or her authorized scope of practice and in accordance with all applicable statutes and regulations; and (II) Trained to administer the medication; or (3) If the conditions set forth in subsection 2 are satisfied, with the assistance of a caregiver employed by the residential facility. 2. A caregiver employed by a residential facility may assist a resident in the administration of the medication prescribed to the resident for his or her diabetes if: (a) A physician, physician assistant or advanced practice registered nurse has determined that the resident's physical and mental condition is stable and is following a predictable course. (b) The amount of the medication prescribed to the resident for his or her diabetes is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale. 2. A caregiver employed by a residential facility may assist a resident in the administration of the medication prescribed to the resident for his or her diabetes if: (c) A written plan of care by a physician or registered nurse has been established that: (1) Addresses possession and assistance in the administration of the medication for the resident's diabetes; and (2) Includes a plan, which has been prepared under the supervision of a registered nurse or licensed pharmacist, for emergency intervention if an adverse condition results.		INCLUDE). MAR of each resident being serviced 7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) Log will be review monthly and quarter for improvements	

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	Inspector Comments: Based on observation, interview, record review and document review the facility failed to ensure 2 of 2 residents reviewed for diabetes (Resident #1 and #11), and requiring assistance to safely administer injectable medications, were not admitted to the facility when the facility lacked staff who were trained and competent to assist in the administration of insulin. Findings include: Resident #1 Resident #1 was admitted to the facility on 04/15/2025, with diagnoses including type two diabetes mellitus and Alzheimer's dementia. A Physician's Note dated 02/13/2025, documented Resident #1's blood glucose was trending up and was sporadically high after meals; however, with dementia, it was hard to track and was hard for the resident to give insulin with each meal. A Resident Assessment dated 03/14/2025, documented Resident #1 required significant (total) assistance with medication administration by a Medication Technician. A physician signed History and Physical dated 03/17/2025, documented Resident #1 was not able to self-administer medications, prescriptions or over-the-counter (OTC) medications. Staff would centrally store medications and provide assistance in administration. An initial Physician Signed Standard Placement Form dated 03/17/2025, documented Resident #1 had a diagnosis of dementia or other form of cognitive impairment, and was not appropriate to reside in a non-secured assisted living community. Resident #1 required a secured memory care community. An Ultimate User Agreement, signed by Resident #1 and Resident #1's Power of Attorney (POA) and a facility representative on 03/19/2025, documented the POA and			

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	Resident #1 authorized facility staff to possess and administer medications to the resident according to instructions from the resident's physician. Resident #1's Service Plan Entries for June 2025, section titled Medication Administration, documented the resident required total assistance, professional nursing staff would administer insulin per physician's orders. Resident #1's September 2025 Medication Administration Record (MAR) included the following physician orders and documentation related to administration of the medications: -Lantus SoloStar 100 units (U)/ milliliter (ml), inject 10 units subcutaneously (SUB-Q) every evening for type two diabetes mellitus. The order date was 09/04/2025, and the scheduled administration time was 7:00 PM. The medication was documented as administered by Med Techs from 09/07/2025 through 09/16/2025. -Lyumjev 100 U/ml Kwikpen, inject 8 units SUB-Q three times daily before meals plus one unit for every 50 points over finger stick blood sugar (FSBS) 150. The order date was 09/04/2025, and the scheduled administration times were 7:00 AM, 11:00 AM, and 4:00 PM. The 7:00 AM dose was documented as administered by Med Techs from 09/06/2025 through 09/17/2025, and the 11:00 AM, and 4:00PM doses were documented as administered by Med Techs from 09/05/2025 through 09/16/2025. On 09/17/2025 at 2:36 PM, during a review of Resident #1's medications and in the presence of a Medication Technician (Med Tech) 4, the following medications were observed: -Lantus SoloStar 100 U/ ml pen. -Lyumjev 100 U/ml Kwikpen. On 09/17/2025 at 2:36 PM, the Med Tech 4 verbalized a Licensed Practical Nurse (LPN) employed by the facility administered Resident #1's injectable medication and monitored blood glucose levels. The LPN was unable to be present in the facility, a			

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home health nurse would administer Resident #1's injectable medications. The Med Tech 4 confirmed the home health nurse would come to the facility four times per day per Resident #1's four scheduled administration times.

Resident #11

Resident #11 was admitted to the facility on 09/11/2025, with diagnoses including diabetes mellitus type two and dementia.

On 09/17/2025, a document titled "Special Care Needs" was provided by the facility. The document listed names of residents residing in the facility, service type (assisted living or memory care), outside agencies providing care to residents, residents who were diabetic, residents' use of insulin, and if the insulin was administered by an outside agency or if the resident self-administered the insulin. Resident #11's service type was memory care, the resident was diabetic and received insulin and blood glucose checks through care from a home health company. Resident #11's service type was assisted living, the resident was diabetic and self-administered insulin.

A Physician's Note dated 08/26/2025, documented Resident #11 had progressive memory loss and cognitive decline, presumed to be dementia, and diabetes mellitus type two. The resident's Power of Attorney (POA) reported the resident could not reliably administer the resident's own insulin or check blood glucose. The assessment/plan related to management of the resident's diabetes included starting once weekly Ozempic 0.25 milligrams (mg), increasing dose in one month and adding extended-release Metformin 500 mg at night with intent to try to get the resident off insulin, if possible, but it did not seem to be a likely option.

A physician signed History and Physical dated 09/02/2025, documented Resident #11 had cognitive decline, short and long-term memory loss. The resident was not able to self-administer medications, prescriptions or OTC medications. Staff

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	would centrally store medications and provide assistance in administration. An Ultimate User Agreement, signed by Resident #11's POA and a facility representative on 09/02/2025, documented the POA authorized facility staff to possess and administer medications to the resident according to instructions from the resident's physician. A Resident Assessment dated 09/03/2025, documented Resident #11 required significant (total) assistance with medication administration by a Medication Technician. Resident #11's Service Plan entries for September 2025, section titled Medication Administration, documented the resident required total assistance to administer resident medications per physician's orders as noted on the Medication Administration Record (MAR). Resident #11's September 2025 MAR included the following physician orders and documentation related to administration of the medications: -Insulin Aspart 100 U/ml pen, inject 12 units subcutaneously (SUB-Q) twice daily for type two diabetes mellitus. The order date was 09/11/2025, and the scheduled administration times were 8:00 AM and 5:00 PM. The 8:00 AM dose was documented as administered by Med Tech 1 on 09/13/2025. The 5:00 PM dose was documented as administered by Med Tech 2 from 09/12/2025 through 09/16/2025. -Ozempic 0.25-0.5 milligrams (mg)/dose pen, inject 0.25 mg SUB-Q weekly for diabetes mellitus type two. The order date was 09/11/2025, and the scheduled administration time was 8:00 AM. -Tresiba Flextouch 200 U/ml pen, inject 60-70 units SUB-Q daily at bedtime for type two diabetes mellitus. The order date was 09/11/2025, and the scheduled administration time was 8:00 PM. The medication was documented as administered by Med Tech 2 from 09/12/2025 through 09/16/2025.			

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	On 09/17/2025 at 2:20 PM, during a review of Resident #11's medications and in the presence of an LPN, the following medications were observed: -An Insulin Aspart 100 U/ ml pen. -An Ozempic 0.25-0.5 mg/ dose pen. -A Tresiba Flextouch 200 U/ ml pen. The LPN verbalized the LPN performed blood glucose checks twice per day and either the LPN or a Med Tech would administer insulin to Resident #11 according to the physician's orders. The LPN explained the LPN typically worked Sunday through Wednesday in the facility and when the LPN was not working, a Med Tech would assist Resident #11 "hand overhand" to administer the insulin. The LPN explained "hand over hand" meant Resident #11 would dial the insulin pen to the number of units needed, the Med Tech would check the number of units dialed and screw the needle onto the insulin pen then hand the pen back to the resident, the Med Tech would place the Med Tech's hand over the resident's hand and guide the resident to the injection site, and the resident would press the button to administer the medication. The LPN described Resident #11's mentation/cognitive status as "very poor", explaining the resident had dementia and was confused. The LPN denied Resident #11 was able to safely check their glucose and self-administer insulin without assistance. The LPN verbalized the LPN was not employed by the facility and worked for a home health company which had contracted with the facility. On 09/17/2025 at 3:11 PM, the Resident Services Director (RSD) verbalized the RSD was responsible for overseeing Med Techs and care staff in the facility. The RSD denied any facility staff had received training related to blood glucose checks and administration of injectable medications, as the facility did not administer injections. The facility's Med Techs received medication			

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	management training; however, the training only included oral and topical medications. The only person allowed to check fingerstick blood glucose for residents and administer injectable medications in the facility was the LPN. The LPN worked for a home health company and came to the facility four days per week, Sunday through Wednesday, for ten hours each day. The RSD denied having any residents currently residing in the facility who needed assistance with blood glucose checks or administration of injectable medications. The RSD explained the facility's process for determining if a resident could safely self-administer medications was to get an order from the physician and it was documented in the history and physical upon admission to the facility. On 09/17/2025 at 3:23 PM, the RSD reviewed Resident #11's History and Physical dated 09/02/2025, and confirmed the documentation from the physician indicated the resident was not able to self-administer medications. On 09/17/2025 at 4:51 PM, Med Tech 3, denied Med Tech 3 had administered injectable medications to any residents in the facility. Med Tech 3 explained facility staff were not allowed to administer injectable medications as the facility and its staff were "non-medical" however, staff could assist in the administration of injectable medications. If a resident had an injectable medication ordered, Med Tech 3 verbalized Med Tech 3 would bring the medication to the resident, cue the resident on how to administer the medication and the resident would inject the medication. Med Tech 3 verbalized Resident #11 had ordered insulin injections on a sliding scale. The administering Med Tech would provide Resident #11 with the blood glucose monitor, lay out the blood glucose test strips, read the sliding scale chart, provide the resident with the insulin pens, and instruct the resident on the settings of the insulin pens based on the blood glucose sliding scale and the results of the blood			

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	glucose monitor reading. On 09/17/2025 at 5:54 PM, the Executive Director (ED) verbalized for residents requiring insulin injections, the facility had a nurse from a contracted home health company come to the facility to administer the medication. The ED confirmed the ED was referring to the LPN and verbalized the ED thought the LPN was working in the facility Sunday through Thursday. The ED recalled a second nurse from the home health company was coming to the facility; however, the nurse no longer wanted to come four times per day. The ED could not recall when the second nurse stopped coming and denied any other nurses from the contracted home health company or additional outside services came to the facility to administer injectable medications on days the LPN did not work. The ED confirmed none of the facility's staff had received training to check blood glucose and assist residents to administer injectable medications. The ED verbalized facility staff relied on residents to self-administer injectable medications when the LPN was not available. The ED explained a resident's physician decided if a resident was competent and safe to self-administer injectable medications. The ED denied it would be appropriate for the facility to allow a resident to self-administer medications if the resident's physician had determined the resident was not safe to do so. The ED confirmed none of the facility's staff had received training to check blood glucose and assist residents to administer injectable medications. The ED verbalized neither Resident #1 nor Resident #11 would be appropriate to self-administer injectable medications per the physician notes documented in the residents' clinical records. On 09/17/2025 at 6:05 PM, the ED was notified by the State Agency (SA) of the need for a plan to ensure the immediate safety of residents residing in the facility with physician ordered injectable medications due to the facility's lack of			

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	trained and competent staff available to administer and/or assist in the administration of the medications. Following the notification, the following sequential events occurred on 09/17/2025: -6:23 PM: The ED provided an abatement plan to the SA. -6:30 PM: The first abatement plan was returned the ED for clarification and additional information. -6:48 PM: The ED provided a second abatement plan to the SA. -6:53 PM: The second abatement plan was returned the ED for clarification and additional information. The ED verbalized all scheduled injections for 09/17/2025 had already been administered and the LPN was to return in the morning. The ED and RSD denied being aware of any residents with scheduled administrations due during the evening or bedtime hours of 09/17/2025. -7:10 PM: The ED provided a third abatement plan to the SA. -7:19 PM: The third abatement plan was returned to the ED for clarification and additional information. -7:22 PM: The ED provided a fourth abatement plan to the SA. The ED verbalized the facility requested the LPN to return to the facility to administer ordered injectable medications for the evening and the LPN was going to arrive at 7:30 PM. The ED explained the ED was not able to obtain a formal, finalized, and updated contract with the home health company until the morning of 09/18/2025; however, the ED could contact the home health company and the president of the company which owned the facility to request a draft of the contract. -7:35 PM: The LPN returned to the facility. The LPN explained the LPN returned to the facility to administer injectable medications to residents scheduled for the evening of 09/17/2025 and would return at 7:00 AM on the following day. An “Agreement for Diabetic Care Services,” dated 04/01/2025, documented the agreement was between the facility and the home health company and the purpose was to outline the terms under which the home health company would deliver insulin			

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	administration and diabetic care services to residents of the facility. Services the home health company would provide included daily insulin administration and diabetic care management, oversight and documentation of care provided by nursing staff employed by the home health company. The job descriptions for Med Tech 1 and Med Tech 2, signed 06/16/2024 and 07/16/2024 respectively, documented job duties for MedTech 1 and Med Tech 2 included following outlined procedure, physician's orders, and state laws when assisting or supervising residents with medications. The facility policy titled "Injections," undated, documented injections were to be administered only by the resident themself or by a licensed medical professional (physician, registered nurse, or LPN), according to physician orders and state regulatory requirements. If the resident administered the resident's own injections, physician verification of the resident's ability to do would be maintained in the resident's record. Severity: 2 Scope: 3			
Y 0786 SS= F	**NAC 449.2726(rev. by LCB 109-18 (22) and R043-22** 2. A caregiver employed by a residential facility may assist a resident in the administration of the medication prescribed to the resident for his or her diabetes if: (d) The medication prescribed to the resident for his or her diabetes is not administered by injection or intravenously or is administered using an auto-	Y 0786	786 1) all orders for diabetic needs is being managed by 3rd party Resident 1 still in facility being managed by 3rd party Resident 11 no longer in facility 2) Any resident requiring diabetic management will be serviced by outside 3rd party for diabetic management and orders	02/21/2026

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	injection device in accordance with the requirements of NRS 449.0304 and section 13 of this regulation. (of LCB File No. R109 -18). (e) The caregiver has successfully completed training and examination approved by the Division pursuant to section 12 of this regulation regarding the administration of such medication. 3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that: (a) Sufficient amounts of medicines, equipment to perform tests, syringes, needles and other supplies are maintained and stored in a secure place in the facility; (b) Syringes and needles are disposed of appropriately in a sharps container which is stored in a safe place; and (c) The caregivers responsible for the resident have received instruction in the recognition of the symptoms of hypoglycemia and hyperglycemia by a medical professional who has been trained in the recognition of those symptoms. Inspector Comments: Based on observation, interview, record review, and		3) 3rdparty will keep MAR of each resident being managed by their service and will be reviewed with facility 4) Resident care director and memory caredirector 5) The date the corrective action will becompleted (MUST INCLUDE); AND 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). Mar per patient 7) How you will identify and correct other area shaving potential to be affected by the same deficient practice (if applicable) Log will be review monthly and quarter for improvements	

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	document review, the facility failed to ensure a physician's order for insulin with a dose range was clarified prior to administering the medication for 1 of 2 residents reviewed for diabetes (Resident #11) and to prevent staff who had not received training related to the administration of injectable medications from assisting 2 of 2 residents reviewed for diabetes (Residents #11 and #1) with the administration of insulin. Findings include: Resident #11 Resident #11 was admitted to the facility on 09/11/2025, with diagnoses including diabetes mellitus type two and dementia. On 09/17/2025, a document titled "Special Care Needs" was provided by the facility. The document listed names of residents residing in the facility, service type (assisted living or memory care), outside agencies providing care to residents, residents who were diabetic, residents' use of insulin, and if the insulin was administered by an outside agency or if the resident self-administered the insulin. Resident #11's service type was memory care, the resident was diabetic and received insulin and blood glucose checks through care from a home health company. Resident #11's service type was assisted living, the resident was diabetic and self-administered insulin. A Physician's Note dated 08/26/2025, documented Resident #11 had progressive memory loss and cognitive decline, presumed to be dementia, and diabetes mellitus type two. The resident's Power of Attorney (POA) reported the resident could not reliably administer the resident's own insulin or check blood glucose. A History and Physical dated 09/02/2025 documented Resident #11 had cognitive decline, short and long-term memory loss. The resident was not able to self-administer medications, prescriptions or over-the-			

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	counter (OTC). Staff would centrally store medications and provide assistance in administration. An Ultimate User Agreement, signed by Resident #11's POA and a facility representative on 09/02/2025, documented the POA authorized facility staff to possess and administer medications to the resident according to instructions from the resident's physician. A Resident Assessment dated 09/03/2025, documented Resident #11 required significant (total) assistance with medication administration by a Medication Technician (Med Tech). Resident #11's Service Plan for September 2025, section titled Medication Administration, documented the resident required total assist, administer resident medications per physician's orders as noted on the Medication Administration Record (MAR). Resident #11's September 2025 MAR included the following physician orders and documentation related to administration of the medications: -Insulin Aspart 100 units (U)/ milliliter (ml) pen, inject 12 units subcutaneously (SUB-Q) twice daily for type two diabetes mellitus. The order date was 09/11/2025, and the scheduled administration times were 8:00 AM and 5:00 PM. The 8:00 AM dose was documented as administered by Med Tech 1 on 09/13/2025. The 5:00 PM dose was documented as administered by Med Tech 2 from 09/12/2025 through 09/16/2025. -Ozempic 0.25-0.5 milligrams (mg)/ dose pen, inject 0.25 mg SUB-Q weekly for diabetes mellitus type two. The order date was 09/11/2025, and the scheduled administration time was 8:00 AM. -Tresiba Flextouch 200 U/ ml pen, inject 60-70 units SUB-Q daily at bedtime for type two diabetes mellitus. The order date was 09/11/2025, and the scheduled administration time was 8:00 PM. The medication was documented as administered by Med Tech 2 from 09/12/2025 through 09/16/2025.			

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	On 09/17/2025 at 2:20 PM, during a review of Resident #11's medications and in the presence of a Licensed Practical Nurse (LPN), the following medications were observed: -An Insulin Aspart 100 U/ ml pen. -An Ozempic 0.25-0.5 mg/ dose pen. -A Tresiba Flextouch 200 U/ ml pen. The pen lacked a pharmacy label and any other instructions from the physician related to The LPN verbalized Resident #11 required blood glucose checks twice per day and either the LPN or a Med Tech would check or assist the resident to check blood glucose and administer insulin according to the physician's orders. The LPN explained the LPN typically worked Sunday through Wednesday in the facility and when the LPN was not working, a Med Tech would assist Resident #11 "hand over hand" to administer the insulin. The LPN explained "hand over hand" meant Resident #11 would dial the insulin pen to the number of units needed, the Med Tech would check the number of units dialed and screw the needle onto the insulin pen then hand the pen back to the resident, the Med Tech would place the Med Tech's hand over the resident's hand and guide the resident to the injection site, and the resident would press the button to administer the medication. The LPN described Resident #11's mentation/cognitive status as "very poor", explaining the resident had dementia and was confused and denied Resident #11 was able to safely check the resident's glucose and self-administer insulin without assistance. The LPN acknowledged Resident #11's MAR included an ordered dose of 60-70 units of Tresiba and the medication was documented as administered from 09/12/2025 through 09/16/2025. The LPN recalled a Med Tech informed the LPN the Med Tech had contacted the physician's office regarding the range order and was told to "just give 60 units". The LPN			

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	verbalized the LPN was not sure if an updated physician's order had been obtained by the Med Tech and verbalized the LPN sent a fax communication to the physician the morning of 09/17/2025 regarding the facility's inability to have range orders for medications. The Health Provider Fax Communication form dated 09/17/2025, documented Resident #11's blood glucose in the morning (a.m.) was 09/16 – 36 and when juice was given, increased to 115. 09/17 – 37, with juice given came up above 100. Orders were Insulin Aspart 100 U/ ml – inject 12 U two times per day, Metformin Hydrochloride (HCl) 500 mg every day, Ozempic 0.25-0.5 mg dose pen weekly (cannot have range), Tresiba 60-70 U every day at bedtime (cannot have range). On 09/17/2025 at 3:11 PM, the Resident Services Director (RSD) verbalized the RSD was responsible for overseeing Med Techs and care staff in the facility. The RSD denied any facility staff had received training related to blood glucose checks and administration of injectable medications as the facility did not administer injections. The facility's Med Techs received medication management training; however, the training only included oral and topical medications. The only person allowed to check fingerstick blood glucose for residents and administer injectable medications in the facility was the LPN. The LPN worked for a home health company and came to the facility four days per week, Sunday through Wednesday, for ten hours each day. The RSD denied having any residents currently residing in the facility who needed assistance with blood glucose checks or administration of injectable medications. The RSD explained the facility's process for determining if a resident could safely self-administer medications was to obtain an order from the physician and it was documented in the history and physical upon admission to the facility. On 09/17/2025 at 3:23 PM, the RSD			

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	reviewed Resident #11's History and Physical dated 09/02/2025, and confirmed the documentation from the physician indicated the resident was not able to self-administer medications. Resident #1 Resident #1 was admitted to the facility on 04/15/2025, with diagnoses including type two diabetes mellitus and Alzheimer's dementia. A Physician's Note dated 02/13/2025, documented Resident #1's glucose was trending up and was sporadically high after meals; however, with dementia, it was hard to track and was hard for the resident to give insulin with each meal. A Resident Assessment dated 03/14/2025, documented Resident #1 required significant (total) assistance with medication administration by a Med Tech. A physician signed History and Physical dated 03/17/2025, documented Resident #1 was not able to self-administer medications, prescriptions or OTC. Staff would centrally store medications and provide assistance in administration. An initial physician signed Standard Placement Form dated 03/17/2025, documented Resident #1 had a diagnosis of dementia or other form of cognitive impairment, and was not appropriate to reside in a non-secured assisted living community. Resident #1 required a secured memory care community. An Ultimate User Agreement, signed by Resident #1 and Resident #1's POA and a facility representative on 03/19/2025, documented the POA and Resident #1 authorized facility staff to possess and administer medications to the resident according to instructions from the resident's physician. Resident #1's Service Plan Entries for June 2025, section titled Medication Administration, documented the resident			

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	required total assistance, professional nursing staff would administer insulin per physician's orders. Resident #1's September 2025 MAR included the following physician orders and documentation related to administration of the medications: -Lantus SoloStar 100 units (U)/ milliliter (ml), inject 10 units subcutaneously (SUB-Q) every evening for type two diabetes mellitus. The order date was 09/04/2025, and the scheduled administration time was 7:00 PM. The medication was documented as administered by Med Techs 09/07/2025 through 09/16/2025. -Lyumjev 100 U/ml Kwikpen, inject 8 units SUB-Q three times daily before meals plus one unit for every 50 points over finger stick blood sugar (FSBS) 150. The order date was 09/04/2025, and the scheduled administration times were 7:00 AM, 11:00 AM, and 4:00 PM. The 7:00 AM dose was documented as administered by Med Techs 09/06/2025 through 09/17/2025, and the 11:00 AM, and 4:00PM doses were documented as administered by Med Techs 09/05/2025 through 09/16/2025. On 09/17/2025 at 2:36 PM, during a review of Resident #1's medications and in the presence of a Med Tech, the following medications were observed: -Lantus SoloStar 100 U/ ml pen. -Lyumjev 100 U/ml Kwikpen. On 09/17/2025 at 2:36 PM, the Med Tech 4 verbalized an LPN employed by the facility administered Resident #1's injectable medication and monitored blood glucose levels. When the LPN was unable to be present in the facility, a home health nurse would administer Resident #1's injectable medications. The Med Tech 4 confirmed the home health nurse would come to the facility four times per day as per Resident #1's four scheduled administration times. On 09/17/2025 at 4:51 PM, a Med Tech 3 denied the Med Tech had administered injectable medications to any residents in the facility. The Med Tech 3 explained facility staff were not allowed to administer			

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	injectable medications as the facility and its staff were “non-medical.” If a resident had an injectable medication ordered, the LPN would assist the resident. If the LPN was not working or not available, the Med Tech 3 verbalized the Med Techs would assist the resident. The Med Tech 3 verbalized the Med Tech 3 had assisted Resident #1 with checking the resident’s blood glucose and administering insulin according to a sliding scale. Assistance included bringing all supplies to the resident’s room, handing the resident an alcohol wipe, the resident pricked the resident’s finger and moved the finger to the glucometer. The Med Tech 3 explained Resident #1 was on a sliding scale. After checking blood glucose, Resident #1 would dial the number of units needed on the insulin pen and the Med Tech 3 would tell Resident #1 if the Med Tech 3 thought the resident needed more units than what the resident had dialed. Resident #1 would self-inject the medication. On 09/17/2025 at 5:54 PM, the Executive Director (ED) verbalized for residents requiring insulin injections, the facility had a nurse from a contracted home health company come to the facility to administer the medication. The ED confirmed the ED was referring to the LPN and verbalized the ED thought the LPN was working in the facility Sunday through Thursday. The ED recalled a second nurse from the home health company was previously coming to the facility; however, the nurse no longer wanted to come four times per day. The ED could not recall when the second nurse stopped coming and denied any other nurses from the contracted home health company or additional outside services were coming to the facility to administer injectable medications on days the LPN did not work. The ED explained a resident’s physician decided if a resident was competent and safe to self-administer injectable medications. The ED denied it would be appropriate for the facility to allow a resident to self-administer medications if the resident’s physician had determined the			

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	resident was not safe to do so. The ED confirmed none of the facility's staff had received training to check blood glucose and assist residents to administer injectable medications. Facility staff relied on residents to self-administer injectable medications when the LPN was not available. An "Agreement for Diabetic Care Services," dated 04/01/2025, documented the agreement was between the facility and the home health company and the purpose was to outline the terms under which the home health company would deliver insulin administration and diabetic care services to residents of the facility. Services the home health company would provide included daily insulin administration and diabetic care management, oversight and documentation of care provided by nursing staff employed by the home health company. Job descriptions for Med Techs 1, 2, and 3, signed 06/16/2024, 07/16/2024, and 11/25/2024 respectively, documented job duties for Med Tech 1 and Med Tech 2 included following outlined procedure, physician's orders, and state laws when assisting or supervising residents with medications. The facility policy titled "Injections," undated, documented injections were to be administered only by the resident themself or by a licensed medical professional (physician, registered nurse, or LPN), according to physician orders and state regulatory requirements. If the resident administered the resident's own injections, physician verification of the resident's ability to do so would be maintained in the resident's record. The facility policy titled "Telephone Orders," undated, documented telephone orders were not permitted. If a prescriber attempted to give a telephone order, staff would request an order be faxed to the facility. The Facility policy titled "Medication			

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	Management," effective 06/09/2023, documented medication supervision and assistance to be defined as a resident requiring standby supervision of physical assistance with medications such as the following -physically obtaining the medication from a storage are for the resident. -opening and closing medication containers. -reading the medication label to the resident and verifying correct medication dose and strength. -preparing necessary items. -providing physical assistance; or -observing and documenting the medication and dose taken. Severity: 2 Scope: 3			
Y 0850 SS= D	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	Y 0850	850 When completing your Plan of Correction,you must address all of the following: 1) Physical examination scheduled with GSC 2) History and Physical added to log 3) Allresidents will be added to log and review monthly 4) Resident care director and or memory care director 5) 3/28/2026 6) You must attach all supporting documents into the system (MUST INCLUDE). Log attached	02/21/2026

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	10953	A. BUILDING _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSET RENO MEMORY CARE	6205 SHARLANDS AVE, RENO, NEVADA ,89523

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	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 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		7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) Log will be reviewed monthly and quarterly for any improvements	

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	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. Inspector Comments: Based on record review, interview and document review, the facility failed to ensure a resident had obtained an annual physical examination for 1 of 15 sampled residents (Resident #13). Findings include: Resident #13 Resident #13 was admitted to the facility on 08/02/2024 with diagnoses including chronic obstructive pulmonary disease and emphysema. Resident #13's initial physical examination was dated 08/02/2024. The resident’s record lacked documented evidence a physical examination had been completed for 2025. On 09/17/2025 at 2:02 PM, the Resident Services Director confirmed Resident #13's only physical examination was completed upon admission and had not completed in 2025. The facility policy titled, "Allowable Health Conditions," undated, documented a resident would receive a physical examination upon admission and every 365 days thereafter by a licensed provider. Severity: 2 Scope: 1			
Y 0870 SS= D	NAC 449.2742	Y 0870	870 When completing your Plan of	02/21/2026

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	Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the		Correctionyou must address all of the following: 1) we changed pharmacy services new pharmacy came 10/31/2025 2) New pharmacy has scheduled 6 months out for April 2026 3) Binderwill be kept for pharmacy review and schedule will be kept every 6 months 4) Executive director and or resident care director 5) 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). Schedule sheet 7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) Sheet will be review quarterly	

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	facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a drug regimen review was conducted by a physician, pharmacist of registered nurse at least once every six months for 1 of 15 sampled residents (Resident #3). Findings include: Resident #3 was admitted to the facility with a primary diagnosis of Alzheimer's disease. Resident #3's clinical record documented a drug regimen review completed on 05/14/2024; however, the clinical record lacked documentation of any other drug regimen reviews after the 05/14/2024 date. On 09/17/2025 at 12:44 PM, the Resident Services Director (RSD) verbalized drug regimen reviews were to be completed every six months by the pharmacy for all residents in the facility. Drug regimen reviews were completed to ensure medications were appropriate for the resident, had a documented reason, and had no adverse interactions with other medications. On 09/17/2025 at 6:24 PM, the Administrator verbalized the facility did not have a drug regimen review on site for Resident #3 after the 05/14/2024 drug regimen review. Severity: 2 Scope: 1			
Y 0878 SS= E	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a	Y 0878	878 When completing your Plan of Correction,you must address all of the following:	02/21/2026

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	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 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.		1) resident #3,8 no longer infacility 2) resident #10 medication werelabeled and ordered 3) resident #12 doctor calledfor order and medication ordered 4) resident #13 medication ordered 5) resident #5 order dc as itwas no longer applicable 2) All medication will be labeled perprescription for the appropriate resident 3) New input orders will be sent toPharmacy and uploaded to Emar and green flag will appear and will be reviewedby resident care director or memory care director to be approved. Part of cart audit will be to make sure itemsare correctly labeled. 4) The title of the person (position)responsible for ensuring the plan of correction is implemented (DO NOT INCLUDEPERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Resident care director and or memorycare 5) The date the corrective action willbe completed (MUST INCLUDE); AND 3/28/2026 6) You must attach all supporting documents into the system (MUST INCLUDE).	

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	Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure over-the-counter medications documented the resident name and physician for 1 of 15 sampled residents (Resident #10), ensure resident medications were on-site and available to administer as prescribed for 5 of 15 sampled residents (Resident #12, #8, #13, #5, and #3), and ensure a medication label prepared by the pharmacist matched the physician's order for 1 of 15 sampled residents (Resident #1). Findings include: Resident #10 Resident #10 was admitted to the facility on 06/04/2025, with a diagnosis of Alzheimer's dementia. Resident #10's Medication Administration Record (MAR) dated September 2025, documented the following: -Viacitiv Tablet Chew, 500-500-40 tablet. Take one tablet by mouth daily for osteoporosis. The container lacked the physician's name and the resident's name to identify who to administer the medication. -Vitamin B-12 1000 microgram (mcg) tablet. Take one tablet by mouth daily for supplement. The container lacked the physician's name and the resident's name to identify who to administer the medication. -Vitamin D3 50 mcg tablet. Take one tablet by mouth daily for osteoporosis. The container lacked the physician's name and the resident's name to identify who to administer the medication. -Acetaminophen Extra Strength 500 milligram (mg) tablets. Take two tablets by mouth every 8 hours as needed for pain or fever. The Acetaminophen was not on-site and available to administer to the resident. -Polyethylene Glycol 3350 Powder. Take 17		Cart audit form 7) sheets will be reviewed monthly and quarterly for improvement	

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	grams (gm) by mouth daily as needed for constipation mix in liquid. Resident #10's physician's orders dated 05/12/2025, documented the following: -Viacitiv Calcium 650 mg. Chew one daily by mouth for osteoporosis. -Cyanocobalamin (Vitamin B-12) 1000 mcg tablets. Take one tablet by mouth daily for B12 deficiency. -Vitamin D 2000 international units (IU). Take one tablet daily for osteoporosis. -Acetaminophen 1000 mg tablet. Take one tablet every 8 hours for pain or fever. -MiraLAX (Polyethylene Glycol) 17 gram. Take 17 grams by mouth daily for constipation. On 09/17/2025 at 1:29 PM, the LPN confirmed Resident #10's Viacitiv Tablet Chew, Vitamin B-12, and Vitamin D3 lacked documented evidence of the resident's name and physician to determine the resident to administer the medications. On 09/17/2025 at 1:29 PM, the LPN confirmed Resident #10 did not have Acetaminophen and Polyethylene Glycol on-site and available to administer to the resident. The LPN could not recall how long the medications had not been available for the resident to take. Resident #12 Resident #12 was admitted to the facility on 11/05/2024, with diagnoses including visual loss, dementia, and Crohn's disease. Resident #12's MAR dated September 2025, documented Metamucil Powder. Give 12 grams by mouth three times daily. Mix in 8 ounces of liquid. The Metamucil Powder was not on-site and available to administer to the resident. A physician's order could not be located for Metamucil Powder for Resident #12. On 09/17/2025 at 1:29 PM, the LPN confirmed Metamucil Powder was not on-site and available to administer to Resident #12. The LPN was not sure how long the			

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	medication had been out. On 09/17/2025 at 2:29 PM, the Resident Care Assistant verbalized trying to find the physician's order for Metamucil Powder for Resident #12; however, over 5 hours had passed during the survey and the physician order could not be located nor provided. Resident #8 Resident #8 was admitted to the facility on 02/28/2025 with diagnoses including dementia and cerebrovascular accident. A physician's order, dated 07/16/2025, documented Polyethylene Glycol 3350 Powder, take 17grams by mouth daily, mix in glass of water or juice for constipation. On 09/17/2025 at 4:11 PM, the medication was unable to be located on the medication cart. On 09/17/2025 at 4:12 PM, the Medication Technician (Med Tech) confirmed the Polyethylene Glycol for Resident #8 could not be located on the medication cart. Resident #13 Resident #13 was admitted to the facility on 08/02/2024 with diagnoses including chronic obstructive pulmonary disease and emphysema. A physician's order dated 07/21/2025, documented Olopatadine Hydrochloride 0.2 Percent Solution, instill one drop in both eyes once daily for itchiness and allergy symptoms. On 09/17/2025 at 4:26 PM, the medication was unable to be located on the medication cart. On 09/17/2025 at 4:27 PM, the Med Tech confirmed the Olopatadine Hydrochloride for Resident #13 could not be located on the medication cart. Resident #5			

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	Resident #5 was admitted to the facility 03/28/2024, with diagnoses including cognitive impairment and atrial fibrillation. Resident #5's September 2025 MAR documented Silver Sulfadiazine 1% Cream. Apply cream topically daily for frostbite. A physician's order, dated 03/04/2024, documented Silver Sulfadiazine 1%. Apply a thin layer once daily to skin for frostbite. On 09/17/2025 at 2:03 PM, during a review of resident medications, Resident #5's Silver Sulfadiazine was not present among the resident's medications. On 09/17/2025 at 2:03 PM, the Med Tech 2 confirmed the medication was not present. Resident #3 Resident #3 was admitted to the facility on 04/27/2024, with a primary diagnosis of Alzheimer's disease. Resident #3's September 2025 MAR documented Refresh Tears 0.5% Eye Drops. Instill one drop in both eyes every four hours as needed for dry eyes. On 09/17/2025 at 1:51 PM, during a review of resident medications, Resident #3's eye drops were not present among the resident's medications. On 09/17/2025 at 1:51 PM, the Med Tech 2 confirmed the medication was not present. On 09/17/2025 at 5:13 PM, the Resident Services Director (RSD) verbalized staff were expected to reorder medications seven days prior to administering the last dose, or 30 days if from the veteran's association to prevent missed medication administrations. Resident medications should always be onsite and available to be administered. The facility policy titled, "Medication Refills," undated, documented medication refills would be obtained in a timely manner to ensure residents had all physician ordered			

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	medications available. Resident #1 Resident #1 was admitted to the facility on 04/15/2025, with diagnoses including type two diabetes mellitus and Alzheimer's dementia. A physician's order, dated 04/15/2025, documented to inject Lyumjev two units (U) plus sliding scale one U for every 50 above 150 before meals. Resident #1's September 2025 MAR documented Lyumjev 100 U/milliliter (mL) Kwikpen, inject eight U SUB-Q three times daily before meals plus one unit for every 50 points over finger stick blood sugar (FSBS) 150. On 09/17/2025 at 2:39 PM, during a review of Resident #1's medications, a medication label documented Lyumjev 100 U/mL. Inject before meals, 10 U with breakfast, and 15 U for lunch and dinner. On 09/17/2025 at 2:39 PM, the Med Tech 2 verbalized medication labels, MARs and physician orders should match to prevent administering the wrong medication dose. The Med Tech 2 confirmed the Lyumjev Kwikpen label did not match the resident's MAR. On 09/17/2025 at 5:13 PM, the RSD explained the MAR, physician's order and medication label should match to ensure the medication administration was accurate. The facility policy titled "Medication Management," effective 06/09/2023, documented all medications would be dispensed and labeled per the prescription for the appropriate resident. Changes in medication orders required a label change to reflect the current prescription Severity: 2 Scope: 2			

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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, interview, record review, and document review, the facility failed to ensure discontinued medications were stored away from active medications and destroyed for 1 of 15 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 08/04/2025, with diagnoses including cellulitis, hypothyroidism, encephalopathy, and amnesia. Resident #2's September 2025 MAR documented Meloxicam 7.5 milligram (mg) tablet. Take one tablet by mouth every morning for pain. The medication was discontinued. On 09/17/2025 at 1:35 PM, during a review of Resident #2's medications, a medication	Y 0885	885 When completing your Plan of Correctionyou must address all of the following: 1) Medication was destroyed properly 2) All medication to be destroyed will beremoved from cart by medication technician and put in destruction box 3) Medicationto be destroyed weekly and review monthly on log 4) The title of the person (position)responsible for ensuring the plan of correction is implemented (DO NOT INCLUDEPERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Resident care director and or memorycare 5) The date the corrective action will becompleted (MUST INCLUDE); AND 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). Log of medication 7) How you will identify and correct other areashaving potential to be affected by the same deficient practice (if applicable) log willbe review monthly and quarterly for improvements	02/21/2026

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	label documented Meloxicam 7.5 mg tablets. Take one tablet by mouth daily. On 09/17/2025 at 1:35 PM, a Medication Technician (Med Tech) explained discontinued medications should be placed into the overflow section and destroyed to prevent administration to the resident. The Med Tech confirmed Resident #2's Meloxicam should have been destroyed but was not disposed of as required. The facility policy titled "Medication Management," effective 06/09/2023, documented all discontinued medications would be removed from the medication storage cart and stored in the designated secure area for drugs awaiting destruction. Severity:2 Scope:1			
Y 0890 SS= D	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.** 1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an	Y 0890	890 When completing your Plan of Correction,you must address all of the following: 1) Doctor order was clarify order for medication order 2) All orders that have "and or, no vitalsneeded" will need to be clarified by doctor 3) New input orders will be sent toPharmacy and uploaded to Emar and green flag will appear and will be reviewedby resident care director or memory care director to be approved. Part of cart audit 4) The title of the person (position)responsible for ensuring the plan of correction is implemented (DO NOT INCLUDEPERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS);	02/21/2026

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	administration of medication; and (4) 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, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication. Inspector Comments: Based on interview, observation and record review, the facility failed to ensure the Medication Administration Record (MAR) included accurate documentation for 1 of 15 residents reviewed for medication administration (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 06/04/2025, with a diagnosis of Alzheimer's dementia.		Resident care director and memory care director 5) 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). Monthly log for medication cart audit 7) Logwill be reviewed monthly and quarterly for improvements	

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	Resident #10's MAR dated September 2025, documented Acetaminophen Extra Strength 500 milligram (mg) tablet. Take two tablets by mouth every 8 hours as needed for pain or fever. A physician's order dated 05/12/2025, documented Acetaminophen 1000 mg. Take one tablet by mouth every 8 hours for pain or fever. On 09/17/2025 at 2:29 PM, the Resident Care Assistant provided the physician's order for Resident #10's Acetaminophen and confirmed the MAR did not match the physician's order. The Resident Care Assistant confirmed the MAR documented the Acetaminophen was as needed and the physician's order documented a schedule medication to be taken every 8 hours. Severity: 2 Scope: 1			
Y 0920 SS= D	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 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	Y 0920	920 When completing your Plan of Correction,you must address all of the following: 1) Room 108 Tylenol was removed from room andfamily contacted Resident #12 Hospice was informed to have order for cream Hospice was informed cream will be in med cart 2) What measures or systematic change(s) will beput into place to ensure the deficient practice does not recur (MUST ADDRESS); Family was informed to bring allmedications to medication technician All hospice orders will be in place forall	02/21/2026

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	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, interview, clinical record review, and document review, the facility failed to ensure resident medications were kept secured in the facility for 1 of 15 sampled residents (Resident #12) and in one resident room (Room #108). Findings include: On 09/17/2025, the following resident rooms contained unsecured medications: Room 108 - at 2:13 PM, a bottle of Tylenol was on a dresser next to the television. The resident was not present, and the room was unlocked. The designated medication drawer was locked. The Maintenance Director was present at the time of discovery and acknowledged the medication should be secured. Resident #12 Resident #12 was admitted to the facility on 11/05/2024, with diagnoses including visual		medications 3) Lettersent to all families to remind them all OTC or medications must be given toMedication technician Any resident needing to be on Hospicewill all orders to be reviewed With Medication technician 4) Resident care director and or memorycare director 5) 3/28/2026 6) You must attach all supporting documents intothe system (MUST INCLUDE). Log of resident going hospice and letterto families 7) How you will identify and correct other areashaving potential to be affected by the same deficient practice (if applicable) log willbe review monthly and quarterly for changes	

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	loss, dementia, and Crohn's disease. Resident #12's Medication Administration Record (MAR) dated September 2025, documented Desitin Daily Defense 13 percent (%) cream. Apply cream topically four times daily as needed to buttock and peri area after brief changes. Resident #12's clinical record lacked documented evidence of a physician's order to be able to administer Desitin Cream. An Ultimate User Agreement, dated 10/31/2024, documented the resident agreed to have the facility possess and administer all medications to the resident. On 09/17/2025 at 1:29 PM, during medication review, Resident #12 did not have Desitin Cream onsite and available to administer to the resident. On 09/17/2025 at 1:29 PM, the Licensed Practical Nurse (LPN) confirmed Resident #9 did not have Desitin Cream onsite and available to administer and verbalized the resident often was left with the Desitin Cream in the resident's room. On 09/17/2025 at 2:45 PM, Resident #12's door was unlocked and the resident had two visitors in the room. Located inside Resident #12's room, on a bedside table next to the resident's bed, was a used tube of Desitin Cream. The resident verbalized the cream was in the resident's room at all times to use if the resident wanted to use the cream. On 09/17/2025 at 2:45 PM, the Resident Care Assistant explained the resident was not to possess nor administer medications by the resident and all of the resident's medication were required to be secured at all times. The Resident Care Assistant verbalized the Medication Technicians were leaving the Desitin cream in the resident's room; however, were aware the resident did not have an order to self-administer medications and should have secured the medication in the medication cart after administration. The Resident Care Assistant			

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	confirmed Resident #12 had Desitin Cream in the resident's room unsecured. Severity: 2 Scope: 1			
Y 0930 SS= E	**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 diet or medication he requires.	Y 0930	930 When completing your Plan of Correction you must address all of the following: 1) A)resident # 14, 9 TB scheduled B) resident #4 ADL updated C) resident #2,4,5 Mar updated 2) What measures or systematic change(s) will beput into place to ensure the deficient practice does not recur (MUST ADDRESS); TB added to log, ADL will be updated on change of condition Mar added to medication room audit 3) Log will be review monthly and med room audit monthly and adl as updated for memory care every 4 months and change of condition, assisted 6 months or change of condition 4) Residentcare director and or memory care director 5) 3/28/2026 6) You must attach all supporting documents into the system (MUST INCLUDE). Log and audit attached 7) How you will identify and correct other	02/21/2026

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	(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; (2) Each time there is a change in the mental or physical		areas having potential to be affected by the same deficient practice (if applicable) review monthly and quarterly for improvement	

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	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. 3. Except as otherwise provided			

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	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 record review, interview and document review, the facility failed to ensure 2 of 15 sampled residents (Resident #14 and #9) met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A, failed to ensure an annual Activities of Daily Living Assessment (ADL) was completed for 1 of 15 sampled residents (Resident #4), and failed to maintain complete and accurate resident records by failing to ensure physician orders were retained for 3 of 15 sampled residents (Resident #2, #4, and #5). Findings include: TB Testing Resident #14 Resident #14 was admitted to the facility on 01/30/2025, with a diagnosis of dyspnea. Resident #14's record included documentation of a one-step TB skin test administered on 01/08/2025, and read on 01/10/2025. A printed document in Resident #14's record included a line listing titled "Immunizations". A TB 1 Step Mantoux (PPD) test was documented as administered on 01/15/2025 and had a result status of "Negative". The line listing and the remainder of Resident #14's record lacked documentation related to who placed			

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	and read the second step TB test and the date the test was read. On 09/17/2025 at 2:08 PM, the Resident Services Director (RSD) confirmed Resident #14's record lacked complete documented evidence of a two-step TB test. Resident #9 Resident #9 was admitted to the facility on 08/29/2024, with diagnoses including dementia, chronic obstructive pulmonary disorder, and schizophrenia. Resident #9's clinical record documented a QuantiFERON TB test dated 02/01/2024, with a negative result and an annual QuantiFERON TB test dated 07/16/2025, with a negative result. On 09/17/2025 at 2:06 PM, the Resident Care Manager explained all residents were to receive either a two-step TB test or QuantiFERON TB test upon admission and a one-step or QuantiFERON TB test annually thereafter. The Resident Care Manager verbalized the annual TB tests must be completed in the same month as the previous TB tests and confirmed Resident #9's annual TB test was over five months late. ADL Assessment Resident #4 Resident #4 was admitted to the facility on 01/23/2024 with diagnoses including Alzheimer's Disease and dementia. An ADL Assessment for Resident #4 was dated 07/30/2024. The resident's record lacked documentation an ADL Assessment had been completed for 2025. On 09/17/2025 at 12:20 PM, the Resident Services Director confirmed Resident #4 did not have an ADL Assessment completed in 2025. The facility policy titled, "Activity Assessments," undated, documented a			

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	resident's daily living skills would be assessed, but lacked language on the frequency of the assessments. Physician Orders Resident #2 Resident #2 was admitted to the facility on 08/04/2025, with diagnoses including cellulitis, hypothyroidism, encephalopathy, and amnesia. Resident #2's September 2025 Medication Administration Record (MAR) documented the following medications: -Acetaminophen 325 milligram (mg) tablet. Take two tablets by mouth every six hours as needed for pain. -Zinc 50 mg tablet. Take 25 mg by mouth daily for wound healing. Resident #2's September 2025 MAR did not include Hyoscyamine. On 09/17/2025 at 1:19 PM, during a review of Resident #2's medications, the following were observed: -Hyoscyamine sublingual 0.125 mg. place one tablet under tongue every 6 hours as needed for terminal secretions. -Acetaminophen 325 mg tablets were not present among the resident's medications. -Zinc 50 mg tablets were not present among the resident's medications. Resident #2's clinical record lacked documented evidence of a physician's order for Hyoscyamine, Acetaminophen, and Zinc. Resident #4 Resident #4 was admitted to the facility on 01/23/2024, with diagnoses include Alzheimer's disease and dementia. Resident #4's September 2025 MAR documented the following medications: -Acetaminophen 325 mg tablet. Take two tablets by mouth every eight hours as needed for fever and mild to moderate pain. -Child Acetaminophen 160 mg/5 milliliters (mL). Take 15 mL by mouth every six hours			

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	as needed inside cheek and give slow for fever/temperature greater than 101 degrees Fahrenheit. -Lorazepam concentration 2 mg/mL. Take 0.25 mL by mouth every two hours as needed for anxiety or dyspnea. On 09/17/2025 at 2:28 PM, during a review of Resident #4's medications, the following were observed: -Acetaminophen 325 mg tablets were not present among the resident's medications. -Child Acetaminophen 160 mg/5 milliliters (mL). Take 15 mL by mouth every eight hours as needed inside cheek and give slow for fever/temperature greater than 101 degrees Fahrenheit. -Lorazepam concentration 2 mg/mL was not present among the resident's medications. Resident #4's clinical record lacked documented evidence of a physician's order for Acetaminophen, Child Acetaminophen, and Lorazepam. Resident #5 Resident #5 was admitted to the facility on 03/28/2024, with diagnoses including cognitive impairment and atrial fibrillation. Resident #5's September 2025 Medication Administration Record (MAR) documented the following medications: -Gabapentin 100 mg capsule. Take one capsule by mouth three times daily as needed for fibromyalgia. Resident #5's September 2025 MAR did not include Clobetasol Propionate Cream or Desonide Cream. On 09/17/2025 at 1:55 PM, during a review of Resident #5's medications, the following were observed: -Clobetasol Propionate 0.05% Cream. Apply a thin layer to affected areas two times daily as needed for skin condition dermatitis on lower legs. -Desonide 0.05% Cream. Apply a thin layer to affected area twice a day as needed or skin condition seborrheic dermatitis of face and ears.			

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	-Gabapentin 100 mg capsule was not present among resident #5's medications Resident #5's clinical record lacked documented evidence of a physician's order for Clobetasol Propionate Cream, Desonide Cream, and Gabapentin. On 09/17/2025 at 5:53 PM, the Resident Services Director (RSD) verbalized the facility did not retain all orders for all resident medications. The RSD explained the pharmacy required physician's orders with the wet signatures for distribution, so the facility sent all physician's orders to the pharmacy without retaining a copy. The RSD verbalized if the physician's order was not present among the resident's clinical record, the facility did not have it. The facility policy titled, "Medication Management," effective 06/09/2023, documented all discontinued medications would be removed from the medication storage cart and stored in the designated secure area for drugs awaiting destruction. Severity: 2 Scope: 2			
Y 1520 SS= C	NAC 449.011926 and R004-24 Policy on handling of complaints; log of complaints. (NRS 449.0302) A facility shall: 1. Develop and adopt a written policy on how a complaint with the facility: (a)May be filed with the facility; and (b)Will be documented, investigated and resolved; and 2. Maintain a log that lists: (a) All complaints concerning prohibited discrimination that are filed with the facility; (b) The actions taken by the facility to investigate and resolve	Y 1520	1520 When completing your Plan of Correction, you must address all of the following: 1) Complaint from was created and suggestion boxes ordered 2) Compliant form placed by suggestion boxes 3) Logof complaints will be kept and reviewed 4) Front desk 5) 3/28/2026	02/21/2026

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	each complaint; and (c) If no action was taken concerning a complaint, an explanation as to why no action was taken. Inspector Comments: Based on interview and document review, the facility failed to develop and adopt a written policy on handling complaints or a log of such complaints. Findings include: A review of the policy binder revealed no policy for how a complaint would be filed, documented, investigated, or resolved was provided with other facility policies. On 09/17/2025 at 3:20 PM, the Executive Director verbalized such a policy did not exist, nor had a log to document complaints been created. Severity: 1 Scope: 3		6) Log sample 7) log review monthly for trends and quarterly for improvements	
Y 1700 SS= D	**NRS 449.1845** **Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment.** 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified	Y 1700	1700 1) resident #9 no longer in the facility 2) new system notifies you of assessment coming due 3) Assessment report printed monthly 4) resident care director and or memory caredirector 5) 3/28/2026	02/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10953	A. BUILDING _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident:		6) Sample report 7) How you will identify and correct other areas having potential to be affected by the same deficient practice (if applicable) report will be reviewed monthly and quarterly for any new updates	

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	(a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on interview and clinical record review, the facility failed to ensure a standard placement determination accurately completed by a provider annually for a resident with a diagnosis of dementia for 1 of 15 residents (Resident #9). Findings include:			

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	Resident #9 Resident #9 was admitted to the facility on 08/29/2024, with diagnoses including dementia, chronic obstructive pulmonary disease, and schizophrenia. Resident #9's clinical record documented a Physician Placement Determination dated 08/08/2024; however, lacked a Physician Placement Determination for 2025. On 09/17/2025 at 2:06 PM, the Resident Care Manager verbalized the facility only required Physician Placement Determinations to be completed for all residents upon admission and the facility did not complete the Physician Placement Determinations on an annual basis for residents with a diagnosis of Alzheimer's or dementia. The Resident Care Manager confirmed Resident #9 lacked an annual Physician Placement Determination for 2025. Severity: 2 Scope: 1			