STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11069	A. BUILDING _____ B. WING _____	09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMINA LAS VEGAS	2710 WEST CHARLESTON BLVD, LAS VEGAS, NEVADA ,89102

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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 State Licensure survey completed at your facility on 09/02/26. The facility is licensed for 57 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 53. Fifteen resident files and ten employee files were reviewed. The facility received a grade of A.			
Y 0106 SS= D	**NAC 449.0113 and R089-24** 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation in accordance with the requirements of section 2 of R089-24; **Reference - R089-24 Sec. 2**. 1. A person who is required by this chapter to be certified in first aid, cardiopulmonary resuscitation or first aid and cardiopulmonary resuscitation may complete any training, course or program to become certified or to renew certification, as applicable, through: (a) In-person instruction only; (b) A combination of in-person instruction	Y 0106	**First Aid and CPR Training Compliance** **Statement of Deficiency:** Based on record review and interview, the facility failed to ensure 2 of 10 sampled employees completed in-person training for First Aid and Cardiopulmonary Resuscitation (CPR) (Employee #3 and Employee #6 on PTO till 9/23/2026). Both employees have been termed. Employee #6 termed on 9/23 and employee #3 termed on 9/28/26 **1. How the Specific Finding(s) Will Be Corrected** The community will immediately review the training records for Employee #3 and Employee #6 to verify completion of the required in-person First Aid and CPR training, including the required hands-on	10/01/2026

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	and virtual or electronic instruction, if interactive, hands-on skills training or skills verification is provided in person; or (c) Virtual or electronic instruction only, if interactive, hands-on skills training or skills verification is not prerecorded. 2. If a certificate is earned in accordance with the requirements of subsection 1, the Division shall accept a certificate issued by the American Red Cross, the American Heart Association, the Health and Safety Institute or another similar nationally recognized organization as proof of certification or renewal of certification. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 sampled employees completed in person training for first aid and cardiopulmonary resuscitation (CPR) (Employee #3 and #6). Findings include: Employee #3 (E3) was hired on 02/18/26, as a Med Tech. E8's file revealed CPR was completed online on 06/03/26. Employee #6 (E6) was hired on 01/07/26, as a Caregiver. E3's file revealed CPR was completed online on 06/03/26. On 09/2/26 in the morning, the Administrator was unaware the CPR was completed online and was unable to provide documented evidence of in person training. Severity: 2 Scope: 1		skills component. The online CPR training identified in the Statement of Deficiencies will not be considered sufficient to meet the in-person training requirement. If documentation confirming completion of the required in-person First Aid and CPR training cannot be verified, the applicable employee(s) will be scheduled to complete the required training through an approved training provider. Until required in-person training and documentation are verified, the employee(s) will not be permitted to perform duties requiring current First Aid and CPR certification. Upon completion, the community will obtain and maintain documentation identifying the training date, training provider, certification, and verification of the required in-person/hands-on component. **2. Measures/Systematic Changes to Prevent Recurrence** The community will implement a standardized First Aid and CPR Training Verification Process for all employees required to maintain First Aid and CPR certification. The following systematic changes will be implemented: • The new-hire onboarding checklist will specifically identify First Aid and CPR requirements. • The checklist will clearly identify the appriopriate approved trainings, through the State of NV approved sites. • Online-only CPR training will not be accepted as meeting an in-person/hands-on requirement.	

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			• Training documentation will be reviewed prior to an employee being cleared to perform duties requiring current First Aid and CPR certification. • A centralized employee training tracker will be maintained identifying the employee, training date, expiration/renewal date, training provider, and whether the required in-person/hands-on component was completed. • Human Resources/Business Office and department leadership will verify required training documentation during onboarding and before applicable employees begin or continue duties requiring certification. • Renewal dates will be monitored in advance to prevent expired certifications or gaps in required training. • Any missing, incomplete, expired, or unverifiable documentation will be addressed immediately. **3. Monitoring to Ensure the Deficient Practice Does Not Recur** The Administrator/Executive Director or designee will conduct a 100% audit of current employee First Aid and CPR training records for all applicable employees. For the first 90 days following implementation, the Administrator/Executive Director or designee will conduct a monthly audit of applicable personnel files and the training tracker to verify: 1. Required First Aid and CPR training has been completed; 2. Training was completed in person; 3. Required hands-on skills verification	

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			is documented; 4. Certification is current; 5. Documentation is maintained in the employee's file; and 6. Employees are not performing applicable duties without verified training. Any discrepancy identified during the audits will be corrected immediately. Audit findings will be reviewed by the Administrator/Executive Director and maintained as part of the facility's Quality Assurance/Performance Improvement process. Ongoing monitoring will be incorporated into routine personnel and training record audits. **4. Position Responsible** The Administrator/Executive Director, or designee, is responsible for ensuring implementation of this Plan of Correction. Human Resources/Business Office and applicable department leadership will assist with maintaining training records and verifying compliance prior to employees performing duties requiring First Aid and CPR certification. **5. Corrective Action Completion Date** **Completion Date: _____10/1/2026_____** By the completion date, the facility will have: • Records for Employee #3 and Employee #6 on PTO till 9/23/26; • Obtained and maintained supporting documentation; • Corrected any additional deficiencies identified during the	

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			review; • Implemented the standardized First Aid/CPR training verification process; and • Initiated the required monitoring and auditing process. **6. Supporting Documentation** Once documentation is provided from Employee #6 and Employee #8 - Executive Director will email the documentation to the survey team to ensure compliance. As the provided documentaiton will be past the 10 days of the POC. The community will attach and/or maintain all applicable supporting documentation in accordance with regulatory requirements, including: • First Aid and CPR certificates; • Documentation verifying in-person/hands-on training; • Training provider documentation; • New-hire/onboarding checklist; • Completed personnel file audits; • Documentation of corrective action for any additional employees identified during the 100% review; **7. Identification and Correction of Other Areas Potentially Affected** Because the deficient practice could potentially affect other employees required to maintain First Aid and CPR training, the community will conduct a 100% review of all current employees whose positions require First Aid and CPR certification. The review verified that each applicable	

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			employee has completed the required training in the required format and that documentation of the in-person/hands-on component is maintained. Any employee identified with missing, incomplete, expired, or unverifiable training documentation was immediately addressed. Required training will be completed as applicable, documentation will be obtained and maintained, and the employee will not perform duties requiring the certification until compliance has been verified. The community will also review recently hired employees and the onboarding process to ensure the same deficient practice has not occurred in other personnel files.	
Y 0255 SS= E	NAC 449.217 6. A residential facility with **more than 10 residents** must: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Division and the state and local fire safety authorities. Inspector Comments: Based on observation on 09/02/2026, the facility failed to ensure	Y 0255	**1. How the specific finding(s) will be corrected** **A. Expired and Spoiled Food** Upon identification of the findings, the expired milk and cream cheese, as well as the blackberries exhibiting visible signs of mold/spoilage, were removed from food service areas and discarded in accordance with facility food safety procedures. A complete inspection of all food storage areas was conducted, including side kitchen refrigerators, the walk-in cooler, dry storage, freezers, and other food storage locations, to identify and remove any additional expired, damaged, spoiled, or otherwise unacceptable food items. Food storage areas were cleaned and	09/08/2026

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	the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the side kitchen fridges, milk was expired 09/01/26 and cream cheese cups were expired 06/11/2026. In the walk-in cooler, blackberries were seen with visible signs of mold and spoilage. 2. Major Violations: a. The dumpster enclosure was soiled with debris. Severity: 2 Scope: 2		organized as necessary, and remaining food items were reviewed for expiration dates, product condition, proper storage, and appropriate labeling. **B. Dumpster Enclosure** The dumpster enclosure was immediately inspected and cleaned. Debris and solid waste located outside the receptacle were removed, and the enclosure was cleaned to restore the area to an acceptable sanitary condition. *Photos attached The area will continue to be maintained free of accumulated debris, refuse, and soil outside of the designated receptacle. **2. Measures/Systematic Changes to Prevent Recurrence** **A. Food Expiration and Food Quality Controls** The community will implement a documented food storage inspection process to provide an additional systematic check of food expiration dates and product condition. Kitchen staff will conduct documented inspections of refrigerators, freezers, walk-in coolers, and dry storage areas at least twice weekly and as needed**.** The inspection will include: • Verification of expiration/use-by dates. • Removal of expired food items. • Inspection for visible mold, spoilage, discoloration, damaged packaging, or other signs that food is no longer suitable for service. • Verification that opened food products are appropriately labeled and dated. • Verification that food is properly stored and organized.	

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			• Use of a first-expire/first-out (FEFO) process to ensure products approaching expiration are identified and used appropriately. • Immediate removal and disposal of any food determined to be expired or unsuitable for use. In addition to the routine kitchen inspections, the Kitchen Manager/Designee will conduct a documented supervisory verification of food storage areas weekly to ensure the process is being consistently followed. **B. Dumpster Enclosure Controls** The dumpster enclosure will be incorporated into the facility's Preventive Maintenance/Environmental Services inspection process. The dumpster enclosure will be inspected **twice weekly and as needed** for: • Debris or solid waste outside of the receptacle. • Accumulated soil or residue. • Overflow or improperly placed refuse. • Overall cleanliness and sanitary condition of the enclosure. Any identified debris will be removed immediately. The enclosure will be pressure washed as needed and whenever routine cleaning does not adequately restore the area to a clean and sanitary condition. **3. Monitoring to Ensure the Deficient Practice Does Not Recur** **A. Food Storage Monitoring** The Kitchen Manager/Designee will review the completed food storage inspection	

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			documentation weekly for four consecutive weeks to verify that inspections are being completed and that expired, spoiled, or otherwise unacceptable food is not present. Following the initial four-week monitoring period, the Executive Director or designee will conduct monthly audits for three months**.** If an expired or spoiled food item is identified during any monitoring audit, the item will be immediately removed and discarded, the finding will be documented, and the responsible staff member will receive additional education/retraining as appropriate. The frequency of monitoring will be increased if trends or repeat findings are identified. **B. Dumpster Enclosure Monitoring** The Kitchen Manager/Designee or Environmental Services designee will verify the dumpster enclosure inspection twice weekly and document completion. The Executive Director or designee will review the documentation weekly for four consecutive weeks to verify compliance. Following the initial four-week monitoring period, the dumpster enclosure will be included in the facility's routine environmental/preventive maintenance audit monthly for three months**.** Any identified deficiency will be corrected immediately and documented. Repeat findings will result in additional staff education and review of the cleaning schedule/process. **4. Identification and Correction of Other Potentially Affected Areas** Because the cited concerns involved food storage and environmental sanitation, the facility conducted a broader review of potentially affected areas rather than	

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			limiting corrective action to the specific items identified during the survey. The facility reviewed: • All kitchen refrigerators. • Walk-in cooler. • Freezers. • Dry food storage areas. • Food preparation/storage areas. • Food products available for resident service. • Dumpster and surrounding waste disposal areas. • Other areas where food storage or waste accumulation could occur. Any expired, spoiled, damaged, improperly labeled, or otherwise unacceptable food identified during the review was removed and discarded. Any debris or sanitation concern identified in the waste disposal areas was corrected immediately. The facility will continue to monitor these areas through the revised inspection and auditing processes described above. **5. Responsible Position** The Executive Director is responsible for ensuring implementation of this Plan of Correction. The Kitchen Manager is responsible for implementation and ongoing oversight of food storage inspection, expiration-date monitoring, and food quality controls. The Environmental Services/Housekeeping Designee is responsible for routine inspection and cleaning of the dumpster enclosure. The Executive Director or designee is responsible for reviewing monitoring documentation and ensuring corrective actions remain effective	

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			6. Corrective action for the specific findings: Completed upon identification of the findings and no later than **09/03/2026**. **Implementation of revised food storage inspection process: 09/08/2026** **Implementation of dumpster enclosure PM inspection process: 09/08/2026** **Initial monitoring period:** Four consecutive weeks following implementation. **Ongoing monitoring:** Monthly for three additional months following completion of the initial monitoring period, with continued incorporation into the facility's routine quality assurance and preventive maintenance processes. **7. Supporting Documentation** The Community will maintain and attach applicable supporting documentation to the Plan of Correction submission system, including, as applicable: 1. Dumpster enclosure cleaning documentation. 2. Revised dumpster enclosure Preventive Maintenance/inspection schedule. 3. All supporting documentation will be maintained by the community and made available to the regulatory agency upon request. **8. Application of Sanctions** The facility acknowledges the regulatory language regarding the application of sanctions. Sanctions, if imposed, will be applied according to NRS 449.163 through 449.170 and NAC 449.9982 through	

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			449.99939. The facility understands that the imposition of sanctions is based on the severity and scope of the deficiency as defined by NAC 449.99861 and NAC 449.9986.	
Y 0072 SS= D	NAC 449.196 & R043-22 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; (d)Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 sampled employees completed an initial 16 hours of medication management training prior to assisting with	Y 0072	**Initial 16-Hour Medication Management Training** **Statement of Deficiency:** Based on record review and interview, the facility failed to ensure 2 of 10 sampled employees completed an initial 16 hours of medication management training prior to assisting with medications (Employee #6 and Employee #8). **1. How the specific finding(s) will be corrected** The community will immediately review the personnel and training records for Employee #6 (on PTO 9/23/2026 and then termed on 9/24/26 - for a no call no show to her scheduled shift) till and Employee #8 (Original was found and is attached) to verify completion of the required initial 16 hours of medication management training prior to assisting with medications. If documentation confirms the required 16 hours of initial medication management training was completed, the documentation will be obtained and maintained in the employee's personnel/training file. Employee #6 - will need to obtain the original 16hours or will need to retake another class. Employee is currently on PTO. Once return we can determine next steps. Employee has been termed prior to returning from PTO - she was a no call no show for her scheduled shift. Until the required training is verified and documented, the employee#6 will not be	10/01/2026

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	medications Employee #6 and #8). Findings include: Employee #6 (E6) was hired on 08/14/25, as a Medication Technician (Med Tech). E6's file revealed an eight-hour medication class was completed on 02/05/26. E6's file lacked documented evidence 16 hours of initial medication management training was completed. Employee #8 (E8) was hired on 02/18/26, as a Med Tech. E8's file revealed an eight-hour medication class was completed on 09/23/25. E8's file lacked documented evidence 16 hours of initial medication management training was completed. On 09/2/26 in the morning, the Administrator reported the Med Techs completed a 16-hour medication class but was unable to provide documented evidence. Severity: 2 Scope: 1		permitted to assist with medication management duties until this initial 16-hour training is obtained. The Administrator/Executive Director or designee will verify completion and documentation before the employee is cleared to perform applicable medication management duties. **2. Measures/Systematic Changes to Prevent Recurrence** The community did a complete audit of Med Tech files to ensure all Medication Technicians have the initial required 16hrs on file. This audit was completed on 9/9/2027. The following processes will be implemented: • The onboarding checklist will specifically identify the requirement for initial 16-hour medication management training when applicable. • Employees will not be assigned or permitted to assist with medication management duties requiring this training until completion has been verified and documented. • A centralized training tracker will be maintained to identify required medication management training, completion dates, expiration/renewal requirements when applicable, and outstanding documentation. • Human Resources/Business Office and the Administrator/Executive Director or designee will communicate regarding any missing or incomplete training documentation before an employee is cleared for applicable medication duties.	

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	11069	A. BUILDING _____ B. WING _____	09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMINA LAS VEGAS	2710 WEST CHARLESTON BLVD, LAS VEGAS, NEVADA ,89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			3. Monitoring to Ensure the Deficient Practice Does Not Recur For the first 90 days following implementation, the Administrator/Executive Director or designee will conduct a monthly audit of applicable employee files to verify: 1. Required initial training has been completed; 2. The required annual training hours has been completed; 3. Documentation is present and readily available; 4. Employees are not performing applicable medication management duties without verified training; and 5. New employees are being appropriately tracked through the onboarding process. Any identified discrepancy will be corrected immediately, and additional training or documentation will be obtained as applicable. Audit results will be reviewed by the Administrator/Executive Director and maintained as part of the facility's Quality Assurance/Performance Improvement process. Continued monitoring will be incorporated into the facility's ongoing employee training and personnel file audits. **4. Position Responsible** The Administrator/Executive Director, or designee, is responsible for ensuring implementation of this Plan of Correction. Human Resources/Business Office and applicable department leadership will assist with maintaining training records and ensuring employees meet training requirements prior to performing applicable	

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			medication management duties. **5. Corrective Action Completion Date** By the completion date, the facility will have: • Employee #6 will need to provide us with the appriopriate next steps. • Employee #8 record has been updated and certificate is attached. • Obtained and/or completed required documentation of the initial 16-hour medication management training; • Completed a 100% review of applicable current employees; 9/9/2026 completed • Corrected any additional identified deficiencies; none found • Initiated the required monitoring and auditing process. **6. Supporting Documentation** The community will attach and/or maintain all applicable supporting documentation in accordance with regulatory requirements, including: • Employee training records/certificates; Employee #8 attached. Employee #6 is on PTO till 9/23/26. • Documentation verifying completion of the initial 16-hour medication management training; • New-hire/onboarding checklist identifying required 16hr and annual 8hr medication management training;	

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			7. Identification and Correction of Other Areas Potentially Affected Because the deficient practice could potentially affect other employees performing medication management duties, the community did conduct a 100% review of all current employees who assist with or perform medication management duties**.** The community also reviewed the onboarding process for recently hired and newly assigned medication management staff to ensure the same deficiency has not occurred in other personnel files.	