STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING AT LONE MOUNTAIN	9708 ENNISKEEN AVE, LAS VEGAS, NEVADA ,89129

(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
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 05/20/26. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's Disease, Category II residents. The census at the time of the survey was seven. Seven resident files and four employee files were reviewed. The facility received a grade of C.			
Y 0104 SS= E	**NAC 449.200** **Personnel files** (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 4 employees had completed background checks and had Nevada Automated Background System (NABS) results for this facility (Employees #3 and #4). Findings include: Employee #3 (E3) E3 was hired on 03/26/25 as a Caregiver. E3 had a NABS clearance letter dated 03/26/25 for a different facility. E3 lacked a	Y 0104	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies? The Administrator did not do their job and was definitely aware of this regulation as they had to do it for 3 facilities. There is no excuse for this but definitely will not happen again. 2) Whatmeasures or systematic change (s) will be put into place to ensure the deficientpractice does not recur? The administrator will do the job properly and will properly review the checklist they have created for new hires and make sure the letter is filed in binder. 3) How thecorrective action(s) will be monitored to ensure that the deficient practice will not recur? The administrator will train the staff on this regulation so that they are aware of this regulation as well, so that they can remind the owner/administration that this must be filed in staffs binder. 4) The title of the person (position)	07/01/2026

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	background check clearance letter for this facility. Employee #4 (E4) E4 was hired on 01/02/24 as a Caregiver. E4 had a NABS clearance letter dated 06/10/25 for another facility. E4 lacked a background check clearance letter for this facility. The NABS system lacked documented evidence E3 and E4 had a background check for the current facility. On 05/20/26 in the afternoon, Employee #4 (E4) verbalized they were not aware the employees needed NABS clearance letters specific to the facility in which they were working. Severity: 2 Scope: 2		responsible for ensuring this is implemented? (JUST USE THE TITLE or POSITION) The Administrator **5)** What datethe corrective action will be completed? 7/1/2026 **6)** SupportingDocuments Letters are attached. 424351 SERENITY LIVING AT MOUNTAINS EDGE - 10764 Comelio Romeo 03/25/2025 484778 SERENITY LIVING AT LONE MOUNTAIN - 11290 Comelio Romeo 07/01/2026 424014 SERENITY LIVING FOR SENIORS - 10765 Malinay Florida 03/15/2025	

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			484777 SERENITY LIVING AT LONE MOUNTAIN - 11290 Malinay Florida 07/01/2026	
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 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	Y 0106	1) How youwill correct the specific finding (s) stated in the Statement of Deficiencies? Employees 1 did take the correct course however the paperwork was improperly filed in the employee's binder. CPR and 1st Aid as the attached documentation verifies the proper course was completed. 2) Whatmeasures or systematic change (s) will be put into place to ensure the deficientpractice does not recur? The staff will be sure to file the documentation properly in the staff's binder. 3) How thecorrective action(s) will be monitored to ensure that the deficient practicewill not recur? The administratior will be sure to verify every 6 months that all documents are filed properly. 4) The title of the person (position) responsible for ensuring this is implemented? (JUST USE THE TITLE or POSITION) The Administrator 5) What datethe corrective action will be completed? By June 27, 2025	06/27/2025

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	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 1 of 4 employees were trained in cardiopulmonary resuscitation (CPR) and first aid (Employee #1). Findings include: Employee #1 (E1) E1 was hired on 08/17/24 as the Administrator. A training certificate in E1's file revealed E1's last CPR and First Aid training was completed online on 05/01/25. E1's training did not include an in-person component. E1's file lacked documented evidence E1 had completed CPR in person, per the requirement. On 05/20/26 in the afternoon, Employee #4 (E4) acknowledged the Administrator had taken an online-only course and was missing the in-person component, as required. Severity: 2 Scope: 1		6) SupportingDocuments The documentation is attached.	
Y 0620 SS= D	NAC 449.2702 and R089-24 4. Except as otherwise provided in this section and NAC 449.2736 and 449.275, a residential facility shall not admit or allow to remain in the facility any person who:	Y 0620	1) How you will correct the specific finding (s) stated in the Statement of Deficiencies? This regulation was new to me, but of course this is not an excuse, but I am know aware and will not happen in the future. In regards, to R5 they are no longer on the vacuum and therefore are welcome to return to the home.	08/06/2026

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	(a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; (d) Requires skilled nursing or other medical supervision on a 24-hour basis; (e) Requires gastrostomy care; (f) Requires vacuum-assisted wound closure therapy; (g) Requires dialysis, if the person is unable to leave the facility to obtain dialysis services; (h) Suffers from a serious staphylococcus infection or other serious infection; or (i) Suffers from any other serious medical condition or requires care not described in NAC 449.2712 to 449.2734, inclusive. 5. A residential facility that provides care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845, may admit or retain a resident who requires confinement in locked quarters. 6. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident		**2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The administrator will make sure the staff is also aware of this regulation for the future and that if it comes up again will contact the administrator as well. In addition, the administrator will educate the home health and Hospice companies as well. **3)** How the corrective action(s) will be monitored toensure the deficient practice will not recur? The administrator will train and educate those involved to this new regulation. **4)** The title of the person (position) responsible for ensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator **5)** What date the corrective action will be completed? By August 6, 2026 **6)** Supporting Documents Documentation attached.	

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	suffering from a serious infection to remain a resident if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing. 7. A person may not reside in a residential facility if the person's physician or the Bureau determines that the person does not comply with the requirements for eligibility. 8. As used in this section, "restraint" means: (a) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (b) A manual method for restricting a resident's freedom of movement or the resident's normal access to his or her body; or (c) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or the resident's normal access to his or her body. Reference - R089-24 Sec. 9. "Bedfast" means: 1. Incapable of changing his or her position in bed without the assistance of another person; or 2. Immobile. Inspector Comments: Based on observation, record review and interview, the facility failed to ensure 1 of 7 residents did not require vacuum-assisted wound			

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	therapy, a prohibited condition (Resident #5). Resident #5 (R5) R5 was admitted on 05/09/25 with a diagnosis of Parkinson's Disease. On 05/20/26 at 10:25 AM, R5 was observed in bed. Per Employee #3 (E3), R5 could not reposition in bed independently. A Medical Professional's Visit Report dated 05/20/26 documented R5's nurse practitioner provided wound care and conducted a wound vacuum (wound vac) change. On 05/25/26, a physical examination of R5 was conducted. The facility emailed the results of the physical exam as well as a progress note dated 06/03/26 from a wound care company to this surveyor. The physical examination revealed R5 had a Stage 4 sacral pressure ulcer and a Stage 2 pressure ulcer of the buttock. The wound care company's progress note dated 06/03/26 documented R5 had a Stage 3 sacral wound upon initial evaluation on 02/06/26. Per the progress note, R5 was seen for follow-up wound care on 02/13/26, at which time the sacral wound had a foul odor and purulent drainage. The progress note documented that R5 was in pain all over, and that consequently the facility called 911. R5 was later readmitted from a rehabilitation facility following hospitalization. The wound care company made a post-rehab visit on 04/21/26, on which date the progress note documented R5 had a wound vac for the stage 4 sacral wound. Subsequent visits by the wound care company on 04/28/26, 05/12/26 (readmit from hospital with urinary tract infection), 05/20/26, and 06/03/26 (readmit from hospital with urinary tract infection) each documented the presence of a wound vac on the sacral wound. On 06/03/26, the wound care company assessed the sacral wound as a Stage 4, and a pressure ulcer on the buttock as a			

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	Stage 2. The wound care company's progress note documented the provider saw R5 weekly on Wednesdays, and that the Home Health company came on Mondays and Fridays and as needed for wound care, wound vac placement, and Foley care. In an interview on 05/20/26 in the afternoon, Employee #4 (E4) verbalized that R5 had been in and out of the hospital since coming to the facility. In a phone interview on 06/10/26 at 3:10 PM, E4 verified R5 had a wound vac for the sacral wound, and received wound care once a week by a wound care company and twice a week by a Home Health company. Severity: 2 Scope: 1			
Y 0930 SS= D	**NAC 449.2749** **Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information.** 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation:	Y 0930	**1)** How you will correct the specific finding (s) statedin the Statement of Deficiencies? The staff will make sure the proper TB test is preformed and the paperwork is filed in the Resident binder. **2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The administrator will discuss with the staff to verify TB Test documentation and to file it in the Residents binder. **3)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The administrator will verify on a monthly basis. **4)** The title of the person (position) responsible for ensuring the plan of correction is implemented?	08/04/2026

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	(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. (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.		(JUST USE THE TITLE or POSITION) The Administrator **5)** What date the corrective action will be completed? August 4, 2026 **6)** Supporting Documents Document is attached	

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	(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 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			

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	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 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 and interview, the facility failed to ensure 1 of 7 residents had completed annual tuberculin (TB) testing (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 05/09/25 with a diagnosis of Parkinson's Disease. The first step of R5's Initial 2-Step TB Skin Test was administered on 04/11/25 and read on 04/14/25, and the second step was administered on 04/26/25 and read on 04/29/25. Both results were negative. R5's file documented an annual 1-Step TB Skin Test was administered on 03/11/26. R5's file lacked documented evidence of the read result of the annual 1-Step TB Skin			

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	Test. On 05/20/26 in the afternoon, Employee #4 (E4) acknowledged the lack of documentation of the read result for R5's annual 1-Step TB Skin Test. Severity: 2 Scope: 1			
Y 0991 SS= F	**NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personal required; training for employees.** (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure alarms were set on exit doors. Findings include: On 05/20/26 at 9:16 AM, the alarm on the sliding glass door leading to the back yard was not set. The alarm did not sound when the door was opened. On 05/20/26 in the morning, Employee #3 (E3) acknowledged the alarm on the sliding glass door was not set, a safety requirement for facilities with an Alzheimer's Disease endorsement. Severity: 2 Scope: 3	Y 0991	**1)** How you will correct the specific finding (s) statedin the Statement of Deficiencies? The administrator will be sure that all required alarms on all doors and windows will be turned on 24/7. **2)** What measures or systematic change (s) will be putinto place to ensure the deficient practice does not recur? The administrator will train the staff. **3)** How the corrective action(s) will be monitored toensure the deficient practice will not recur? The administrator will verify on a bi-monthly basis. **4)** The title of the person (position) responsible forensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator **5)** What date the corrective action will be completed? July 1, 2026 **6)** Supporting Documents Photo	08/06/2026

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Y 0994 SS= F	**NAC 449.2756** **Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required;** (e) Knives, matches, firearms, tools, and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure dangerous items and toxic substances were inaccessible to residents. Findings include: On 05/20/26 at 9:20 AM, a cupboard above the dryer in the laundry area was unlocked. The cupboard contained bottles and aerosol cans of bleach-based multi surface cleaner, laundry stain remover, foaming bathroom cleaner, window cleaner, air deodorizer, disinfectant spray, and furniture cleaner. The laundry area was accessible to all residents, employees, and visitors. On 05/20/26 at 9:23 AM, Employee #3 (E3) verbalized they were about to lock the cupboard. At 10:33 AM, the cupboard was again found unlocked. Employee #2 (E2) and E3 acknowledged the open cupboard with toxic substances, and E2 explained that they were always asking the caregivers to lock the cupboards. Severity: 2 Scope: 3	Y 0994	1) How you will correct the specific finding (s) stated in the Statement of Deficiencies? The Administrator will meet with and train the caregivers. 2) What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The administrator will continue to train all the staff members on the importance of this regulation and will check each time I am there. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The administrator will verify on a weekly basis. 4) The title of the person (position) responsible forensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator 5) What date the corrective action will be completed? July 15, 2026 6) Supporting Documents None	07/15/2026
Y 0995 SS= F	**NAC 449.2756 andR043-22**	Y 0995	1) How you will correct the specific finding (s) stated in the Statement of	07/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	(f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times Inspector Comments: Based on observation and interview, the facility failed to ensure the backyard gate leading to the unsecured front yard was locked. Findings include: On 05/20/26 at 9:16 AM, the padlock on the gate leading from the back yard to the unsecured front driveway was hanging open on the latch. On 05/20/26 in the morning, Employee #3 (E3) explained that the staff usually opens the gate in the morning, and it was kept open all day so that the staff will have easier access to the trash can in the front yard. E3 verbalized the gate was closed at night. Severity: 2 Scope: 3		Deficiencies? The Administrator will meet with and train the caregivers to unlock and lock the gate upon entering and leaving. **2)** What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The administrator will put into place that the nightshift caregiver will check each night to make sure the lock is secure. **3)** How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The administrator will verify on a weekly basis. **4)** The title of the person (position) responsible for ensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator **5)** What date the corrective action will be completed? July 15, 2026 **6)** Supporting Documents Photo attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11290	A. BUILDING _____ B. WING _____	05/20/2026

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Y 1035 SS= D	**NAC 449.2768** **Residential facility which provides care to persons with Alzheimer's disease: Alzheimer's/dementia Training:** 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in	Y 1035	1) How you will correct the specific finding (s) stated in the Statement of Deficiencies? The administrator will make sure the staff properly files the up to date documents within the Administrator's Binder. 2) What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur? The administrator will verify the binder every 6 months to ensure the documents are up to date. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The administrator will verify the binder every 6 months. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? (JUST USE THE TITLE or POSITION) The Administrator 5) What date the corrective action will be completed? 8/6/2026 6) Supporting Documents The documentation is attached.	08/06/2026

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	subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees completed required annual training (Employee #1). Findings include: Employee #1 (E1) E1 was hired as the Administrator on 08/17/24. E1 last completed 8 hours of Alzheimer's and Dementia training on 04/18/25, 4 hours of Alzheimer's Disease training on 04/22/25, 8 hours of Caregiver training on 04/21/25, and Unlicensed Caregiver Infection Control training on 03/10/25. E1's file lacked documented evidence of 3 hours of required annual Alzheimer's Disease training, 8 hours of required annual Caregiver training, and Infection Control training in 2026. On 05/20/26 in the afternoon, Employee #4 (E4) was unable to provide evidence of annual Alzheimer's, Caregiver, and Infection Control training completed by E1 in 2026.			

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	11290	A. BUILDING _____ B. WING _____	**05/20/2026**

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	Severity: 2 Scope: 1			