STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11754	A. BUILDING _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW TERRACE RETIREMENT COMMUNITY	180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005

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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 a complaint investigation completed in your facility on 07/09/26. The census at the time of the survey was 70. The sample size was five. The facility received a grade of A. There was one complaint investigated. Substantiated: 1. Complaint#13782 was substantiated. (See TAGS Y0850 and Y0890) The investigation of the complaint included: Observations of residents receiving care, staff interactions with residents and a tour of the facility. Interviews were conducted with the residents of concern, a resident, Medication Technicians, the Resident Care Coordinator, the former Resident Care Coordinator, the Business Office Manager, Health Services Director and the Administrator. Clinical Record Review of five records. Document Review included facility communication to a resident of concern and facility policy and procedures.			
Y 0850 SS= D	NAC 449.274 and R043-22 **Medical care of resident after illness,**	Y 0850	How you will correct the specific finding (s)stated in the Statement of	07/27/2026

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	injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in 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		Deficiencies (MUST ADDRESS) Resident #3's record was reviewed to ensureall physician orders, laboratory requests, and follow-up documentation werecompleted and accurately reflected in the clinical record. The facilityreviewed the circumstances surrounding the mislabeled urine specimen andreinforced proper specimen collection, labeling, documentation, and follow-upprocedures with all Medication Technicians and caregiving staff. 2) What measures or systematic change(s) will be put intoplace to ensure the deficient practice does not recur (MUST ADDRESS); Re-education will be provided to all Medication Techniciansand designated staff regarding the facility's urine collection policy. A specimen collection checklist will be implemented toverify resident identification, specimen labeling, date/time collection,laboratory notification, and documentation completion. The Resident Care Coordinator or designee will review all physician-orderedlaboratory tests daily to ensure completion and follow-up. Any incomplete laboratory orders will be immediatelyreported to the Health Services Director and Administrator forresolution. 3) How the corrective action(s) will be monitored to ensurethe deficient practice will not recur (MUST ADDRESS); ResidentCare Coordinator or designee will audit 100% of laboratory orders untilsuccessful implementation of new process is completed. Audits willverify completion of ordered tests, proper specimen labeling, laboratoryfollow-up, and documentation. Audit findings will be reported to the Administrator andQuality Assurance/	

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	significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on interview and record review, the facility failed to ensure a resident urine specimen was accurately collected as directed by the resident's provider. (Resident #3) Resident #3 (R3) R3 was admitted to the facility on 05/17/24, with a diagnosis of Alzheimer's.		Performance Improvement committee. Additional staff education and corrective action will beimplemented if deficiencies are identified during audits 4) The title of the person (position) responsible forensuring the plan of correction is implemented RCC, RSD and Administrator	

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	Facility Physician Communication note dated 04/05/26 documented R3 had discoloration in R3's urine and a bad odor. R3's provider instructions documented a urinalysis was ordered for R3. Nurse Practitioner's Visit Notes dated 04/09/26 at 5:24 PM documented a urinalysis was ordered earlier in the week and it was not collected per the lab. A Medication Technician informed the provider that R3's urine was collected, but it was mislabeled with the incorrect last name by a facility staff member, and therefore the Advanced Practice Registered Nurse (APRN) instructed the Medication Technician to recollect the urine and the laboratory's phone number was given to the Medication Technician to call and have R3's urine sample picked up once it was obtained. On 07/09/26 in the morning, R3's file lacked documented evidence the facility had attempted to recollect R3's urine and lacked documented evidence the facility had contacted the laboratory to collect R3's urine on 04/09/26. A Physician Communication note dated 04/11/26 from the facility to R3's APRN documented R3 was sent out to the hospital due to a change in condition. The facility was unable to collect R3's urine and R3 was not acting like themselves. The note documented R3 felt hot. Emergency Department visit notes dated 04/11/26 at 7:16 AM documented R3's reason for visit was a urine specimen collection. R3 was diagnosed with a urinary tract infection. From 04/05/26 to 04/11/26, there was no documented evidence the urinalysis was conducted. There was no documented evidence the facility collected the sample, as the sample was mislabeled. There was no documented evidence the facility followed up with the laboratory as per R3's APRN's instructions. On 07/09/26 in the morning, the Resident			

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	Care Coordinator acknowledged R3's urinalysis was mislabeled. According to the Resident Care Coordinator, a Medication Technician had put the wrong last name on R3's specimen and confirmed R3 was then sent out to the Emergency Department for a urine specimen. Facility Collection of Urine Sample Policy dated 10/02/18 documented the procedure for the collection of urine….. (4) once the specimen is collected, specimen will be transferred to the appropriate container, labeled with resident identifiers, time of collection and date of collection, for transport to the laboratory. Severity: 2 Scope: 1 Complaint # 13782			
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	1 How you will correct the specific finding(s)stated in the Statement of Deficiencies (MUST ADDRESS) Resident #1's Medication Administration Record (MAR) wasreviewed and corrected to reflect the physician's current order. The resident'sprovider was notified regarding the missed medication doses and inaccuratedocumentation. All residents' medication orders and MARs were reviewed toverify accuracy and alignment with current physician orders. 2) What measures or systematic change(s) will be put intoplace to ensure the deficient practice does not recur (MUST ADDRESS); All Medication Technicians will receive re-educationon physician order transcription, MAR documentation requirements, missed-doseprocedures, and physician notification requirements. A medication order verification process will beimplemented requiring supervisory review of all new medication orders and orderchanges. The Health Services Director or designee	07/27/2026

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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 record review and interview, the facility 1) failed to ensure the Medication Administration Record (MAR) was accurate, 2) failed to ensure a resident's record had documented evidence a physician was notified within 12 hours after a resident had missed medications and 3) failed to ensure a resident received medications per the physicians' orders for 1 of 5 sampled residents. (Resident #1) Resident #1 (R1) R1 was admitted to the facility on 03/26/25, with diagnoses including emphysema and		willperform routine MAR reviews to ensure orders are accurately transcribed andmedications are administered as prescribed. A missed-medication tracking log will beestablished to ensure timely physician notification and documentation. 3) How the corrective action(s) will be monitored to ensurethe deficient practice will not recur (MUST ADDRESS); The Health Services Director or designee will conduct frequentaudits of medication records and physician orders. Audits will include verification of physician orders,medication administration documentation, missed-dose follow-up, and physiciannotifications. Findings will be reviewed by the Administrator and discussedduring Quality Assurance/Performance Improvement meetings. Continued noncompliance will result in additional stafftraining and corrective action as appropriate. 4) The title of the person (position) responsible forensuring the plan of correction is implemented RCC, RSD and Administrator	

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	congestive heart failure. A Physician's order dated 05/26/26 documented Spironolactone 25 milligrams (mg), take 1 tablet by mouth daily. R1's May 2026 MAR documented Spironolactone 25 milligrams (mg), take 1 tablet by mouth daily as needed for swelling. The medication was documented as being administered on 05/29/26 and 05/30/26. There was no documented evidence the Spironolactone had been administered to R1 on 05/26/26, 05/27/26, 05/28/26 and 05/31/26. R1's June 2026 MAR documented Spironolactone 25 milligrams (mg), take 1 tablet by mouth daily as needed for swelling. The medication was documented as being administered on 06/16/26, 06/20/26, 06/22/26, 06/23/26, 06/26/26, 06/27/26, 06/28/26, and 06/29/26. There was no documented evidence the Spironolactone had been administered to R1 on 06/01/26, 06/02/26, 06/03/26, 06/04/26, 06/05/26, 06/06/26, 06/07/26, 06/08/26, 06/09/26, 06/10/26, 06/11/26, 06/12/26, 06/13/26, 06/14/26, 06/15/26, 06/17/26, 06/18/26, 06/19/26, 06/21/26, 06/24/ 26, 06/25/26 and 06/30/26. R1's July 2026 MAR documented Spironolactone 25 milligrams (mg), take 1 tablet by mouth daily as needed for swelling. The medication was documented as being administered on 07/02/26, 07/03/26, 07/04/26, 07/05/26 and 07/06/26. There was no documented evidence the Spironolactone had been administered to R1 on 07/01/26, 07/07/26, and 07/08/26. There was no documented evidence the physician was notified after the missed doses of medication until the Administrator notified R1's provider on 07/09/26 at 3:55 PM after an inspector from the Nevada Health Authority notified the Administrator of R1's MAR being inaccurate and R1 not			

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	receiving R1's Spironolactone as prescribed. On 07/10/26 in the morning, the Administrator acknowledged R1's Spironolactone was not administered per the physician's order and confirmed R1's May, June and July 2026 MARs were inaccurate. The Administrator acknowledged the facility had not notified R1's physician of the missed doses until after the inspector was onsite. Facility Medication Policy dated 10/02/18 documented medication assistance will occur in accordance with MD orders. Severity: 2 Scope: 1 Complaint #13782			