STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12218	A. BUILDING _____ B. WING _____	05/27/2026

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KILEY RANCH SENIOR LIVING	6300 DAVID ALLEN PARKWAY, SPARKS, NEVADA ,89436

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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 05/27/2026 The facility is licensed for 86 Residential Facility for Group beds, of which 64 beds provided services to elderly or disabled persons and assisted living services, Category II residents, and 22 beds which provided care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was (86). Twenty resident files and twenty employee files were reviewed. The facility received a grade of D.			
Y 0108 SS= D	**NAC 449.0113 and R089-24** 3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of the facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation in accordance with the requirements of section 2 of R089-24 and that the employee has been tested for tuberculosis must be available for review at all times. The administrator shall make the personnel files available for review by the Bureau upon request. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 1 of 15 sampled employees had timely first aid and Cardiopulmonary Resuscitation (CPR) training. (Employee #6). Findings include:	Y 0108	**Y 0108** 1. Employee #6 was hired on 4-18-26 and had their BLS certification which is not compliant according to the state regulation. She moved from another community in Reno where the certification was accepted. As soon as we caught the incorrect certification, we scheduled them for the CPR/First Aid recognized by the state, but it was past the 30-day timeline. Employee #6 completed the correct training on 5-29-26. (See exhibit #1). 2. We have an employee tracker in place to ensure all certifications are compliant and completed within the 30-day timeline. (See exhibit #2) The Business Office Manager (BOM), Resident Services Director (RCD), and Generations Program Director (GPD) have been trained on compliant CPR/First Aid training to include during the interview process, and when checking all certifications for compliance. 3. The BOM will discuss upcoming certification with the ED at their weekly 1:1. The BOM will bring the tracker to standup every Wednesday to inform department heads of upcoming certifications. 4. ED, BOM, RCD, and GPD	05/29/2026

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	On 05/27/2026 at 10:54 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 04/30/2026 at 2:51 PM, the Administrator provided the completed form with the following information: Employee #6 Employee #6 was hired by the facility as Care Manager with a start date of 04/18/2026. Employee #6's personnel file lacked documented evidence of current CPR training. On 05/27/2026 at 2:55 PM, the Administrator provided the Attestation of Compliance form, signed and dated 05/27/2026, confirming the Administrator had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1		5. Completed	
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must	Y 0250	**Y 0250** 1. On 5-27-26 the temperature reading for the walk-in freezer was 37 degrees. The refrigeration vendor was called immediately and arrived at noon. The technician charged the unit with 4 lbs. of 448A to get the freezer to temp. Other repairs were not completed due to weather. The technician returned on 5-29-26 to make necessary repairs with the appropriate weather conditions. (See exhibit #3) On 7-15-26 the temps began to rise during the day and the refrigeration company was called and came out to inspect and fix. (See exhibit #4) The temp was high again on 8-10-26 and the refrigeration company responded at 7am and made additional repairs. (See exhibit #5) On 5-27-26 the low temp dish machine was reading 100 degrees with a needed temp of 120 or	09/02/2026

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	be appropriately packaged. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure 1) kitchen equipment was functioning appropriately, and 2) dented cans were removed from the storage area. Findings include: **Kitchen Equipment** On 05/27/2026 at 9:19 AM, during the kitchen tour, the freezer was observed to have a temperature reading of 37 degrees. Observed the food in the freezer beginning to defrost and becoming soft. The freezer temperature log posted on the outside of the freezer was last completed 05/24/2026. ON 05/27/2026, the low temperature dishwasher was rinsing at 100 degrees. On 05/27/2026 at 9:23 AM, the Dietary Aide verbalized the dishwasher needed to run above 120 degrees and was currently only running at 100 degrees. On 05/27/2026 at 9:30 AM, the Cook verbalized being unaware the freezer was not functioning appropriately. On 05/27/2026 at 12:39 PM, the Dietary Manager confirmed the freezer was not at the appropriate temperature and the freezer		higher. The plumbing vendor was called out and turned up the water heaters to get the low temp dish machine to 120 degrees or above. (See exhibit #6) Additionally, on 5-27-26 a dented can was found in the dry storage area and immediately removed. 2. (a) Temp logs are being completed in the am and pm on a daily basis. Noting the 7-15-26 and 8-10-26 temps and the quick intervention from the staff to call the refrigeration vendor. (See exhibit #7a and #7b) 2. (b) We have also purchased a thermometer to place in the back of the freezer to get a more accurate reading when the door is left open while stocking the freezer on delivery days or during cleaning. 2. (c) A training meeting was held on 8-26-26 and all kitchen staff were instructed to look at the temps throughout the day when walking by the equipment, and to check for dented cans upon delivery days. A box was placed in the area to place dented cans for destruction. (See exhibit #8) The dishwashers were trained to temp the dish machine for compliance and complete the temp logs. (See exhibit ##9a, #9b, #9c, #9d, and #9e) Signs were hung that day at corresponding sinks with the potential for hot water due to the water heaters being turned up. (See exhibit #10) 3. (a) The ED will make unannounced visits into the kitchen for all temp log compliance and check for dented cans. 3 (b) The ED will walk the kitchen with the Culinary Services Director (CSD) weekly during their 1:1 to inspect equipment is functioning properly, check temp logs, check for dented cans, and overall cleanliness. The company is also looking into transitioning to a high temp dish machine. Quotes are being obtained at this time. 4. ED and CSD 5. Completed with the exception of a potential transition to a high temp machine which does not affect the completion/compliance to this tag	

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	temperatures needed to be logged daily. The Dietary Manager confirmed the dishwasher was not running at the correct temperatures to ensure all dishes were being cleaned and sanitized. **Dented Can** On 05/27/2026 at 9:19 AM, during the kitchen tour, in the dry storage there was one 48 ounces dented can of V8 juice. On 05/27/2026 at 12:39 PM, the Dietary Manager confirmed the dented can of V8 juice should not be stored in the dry storage area with all other canned goods. During the survey on 05/27/2026, the Administrator was unable to provide and policies and procedures related to the kitchen. Severity: 2 Scope: 3			
Y 0515 SS= D	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;	Y 0515	**Y 0515** 1. Resident #9 moved in 2-19-25 with an assessment on that date. Resident #9 had a 30-day assessment per company policy (See exhibit #11) on 3-24-25 which reset the annual to 9-24-25. The community has been tagged on this previously and the POC included the same policy. In accordance with the regulation, Resident #9 had two additional assessments in 2025. 2. Going forward, the community will conduct as assessment at the yearly anniversary date even if other assessments have been conducted throughout the year. For instance, in this case, to be compliant with the tag stating "Resident #9's record lacked documented evidence of an annual review of the resident's service plan," the Resident Care Director (RCD) or Generations Program Director (GPD) would have conducted as assessment on or just before 2-19-26. 3. (a) The RCD and GPD have created a spreadsheet (see Exhibit #12a and #12b) with each resident's move in date and conduct the assessments accordingly. 3. (b) In addition, the Regional Director of Resident Care (RDRC) will continue to send weekly updates with any overdue	09/01/2026

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	(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 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 interview and record review, the facility failed to annually review person-centered service plans for 1 of 20 sampled residents (Residents #9). Findings include: Resident #9 Resident #9 was admitted on 02/19/2025, with diagnoses including malnutrition, anxiety, and cognitive communication impairment. Resident #9's record contained a person-centered service plan dated 02/19/2025.		assessments. 3. (c) ED, RCD, and GPD will be monitoring upcoming assessments per the tracker with the move in date column added. 4. ED, RCD, GPD, and RDRC 5. Completed	

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	Resident #9's record lacked documented evidence of an annual review of the resident's service plan. On 05/27/2026 at 1:34 PM, the Wellness Director was asked to provide the annual person-centered service plan for Resident #9. The Wellness Director did not provide Resident #9's person-centered service plan. Severity: 2 Scope: 1			
Y 0690 SS= D	**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 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;	Y 0690	**Y 0690** 1. Resident #17 had unsecured oxygen in his closet that the DME company left behind for emergency purposes. The metal rack was delivered the following day and the oxygen is secure. (See exhibit #13) 2. The Resident Care Coordinator (RCC) will continue to conduct 15-16 room checks per week and specifically ask residents if there are is any unsecured oxygen in their apartment, both visible and not visible. 3. We will continue to educate residents on proper oxygen storage and communicate with them and their families when unsecured oxygen is found. 4. ED, Resident Care Director, Generations Program Director, and Resident Care Coordinator. 5. Completed	05/28/2026

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	(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 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: (a) The caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen; and (b) All caregivers are trained and knowledgeable regarding hazards and precautions to take when oxygen is in use. Inspector Comments: Based on record review, observation, interview, and document review, the facility failed to ensure oxygen cylinders were stored securely for 1 of 8 residents requiring the use of oxygen. Findings include: On 05/27/2026 at 11:15 AM, in Room 212, an oxygen cylinder was placed directly on the floor of the bedroom next to the door,			

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	unsecured. On 05/27/2026 at 11:15 AM, the Generations Program Director confirmed the oxygen cylinder was not secured as required. Severity: 2 Scope: 1			
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 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	Y 0850	**Y 0850** 1. Resident #8 had a physical exam with a review of systems on 2-6-25 and 2-5-26. (See exhibit ##14a and $14b) In the 2025 survey, the Resident Care Director (RCD) was told to use the Date of Exam under the Resident/Patient Diagnosis and we have been using those dates for compliance. Given those instructions, the General Physical Exam was not two months late. 2. We will continue to notify residents, their families, and their physicians two months in advance that a physical exam is due. For instance if an exam is due 10-31-26, we will start the notification process on or before 8-31-26. 3. (a) The RCD and Generations Program Director (GPD) will continue to use their respective ticklers. (See Exhibit #12a and #12b) to monitor upcoming Physician Reports that are due. 3. (b) The RCD and GPD will continue to communicate with the ED regarding upcoming examinations needed at their weekly 1:1's. 4. ED, RCD, and GPD 5. Completed	09/02/2026

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	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 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.			

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	Inspector Comments: Based on record review and interview, the facility failed to ensure an annual physical examination was completed timely for 1 of 20 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 02/06/2023, with diagnoses including cognitive deficit, atrial fibrillation, and glaucoma. Resident #8's record documented a general physical exam, with a review of systems, dated 03/07/2025 and 05/03/2026. The general physical exam for 2026 was completed two months late. On 05/27/2026 at 1:30 PM, the Wellness Director confirmed Resident #8's physical examination completed in 2026 was completed late. The Wellness Director verbalized physical examinations were to be completed annually. Severity: 2 Scope: 1			
Y 0870 SS= F	NAC 449.2742 **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	Y 0870	**Y 0870** 1. The six month pharmacy review for residents #2, 3, 4, 5, 6, 8, 10, 11, 12, 13, 14, and 15 were late. The company requested that the community change pharmacies in October 2025, effective 11-1-25. In order for the six month medication profile be performed with the then current pharmacy of three years, we requested it be completed before their last day of 10-31-25 as it was originally scheduled for mid November. The pharmacy conducted the six month review 10-27-25. The new pharmacy scheduled their review 5-21-26. We did not schedule the review by 4-27-26 causing the deficiency. We have scheduled	08/26/2026

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(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
	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 facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on clinical document review, record review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse		our next pharmacy review for **11-5-26** to be within the six month period from the last pharmacy review of 5-21-26. (see Exhibit #15) 2. Going forward the Executive Director (ED), Resident Care Director (RCD), and Generations Program Director (GPD) have placed "schedule pharmacy review" on their Outlook calendars one month prior to the required pharmacy review date. 3. The ED will discuss scheduling the review with the RCD and GPD at their weekly 1:1 one month prior to the compliant date. 4. ED, RCD, and GPD 5. Completed	

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	at least once every six months for 12 of 20 sampled residents reviewed for medications residing in the facility longer than six months (Resident #2 #3, #4, #5, #6, #8, #10, #11, #12, #13, #14, and #15). Findings include: Resident #2 Resident #2 was admitted to the facility on 04/06/2024, with diagnoses including dementia, insomnia, and hypertension. Resident #2's clinical record documented a pharmacy review was completed on 10/27/2025 and 05/21/2026. Resident #2's pharmacy review completed on 05/21/2026 was completed one month late. Resident #3 Resident #3 was admitted to the facility on 01/18/2025, with diagnoses including dementia, muscle weakness, and cognitive communication deficit. Resident #3's clinical record documented a pharmacy review was completed on 10/27/2025 and 05/21/2026. Resident #3's pharmacy review completed on 05/21/2026 was completed one month late. Resident #4 Resident #4 was admitted to the facility on 09/27/2023, with diagnoses including alzheimer's, and hypertension. Resident #4's clinical record documented a pharmacy review was completed on 10/27/2025 and 05/21/2026. Resident #4's pharmacy review completed on 05/21/2026 was completed one month late. Resident #5 Resident #5 was admitted to the facility on 01/12/2023, with diagnoses including dementia, hypothyroid, and insomnia. Resident #5's clinical record documented a pharmacy review was completed on			

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	10/27/2025 and 05/21/2026. Resident #5's pharmacy review completed on 05/21/2026 was completed one month late. Resident #6 Resident #6 was admitted to the facility on 09/16/2025, with diagnoses including dementia, muscle weakness, and cognitive communication deficit. Resident #6's clinical record documented a pharmacy review was completed on 10/27/2025 and 05/21/2026. Resident #6's pharmacy review completed on 05/21/2026 was completed one month late. Resident #8 Resident #8 was admitted to the facility on 02/06/2023, with diagnoses including cognitive deficit atrial fibrillation, and glaucoma. Resident #8's clinical record documented a pharmacy review was completed on 10/27/2025 and 05/21/2026. Resident #8's pharmacy review completed on 05/21/2026 was completed one month late. Resident #10 Resident #10 was admitted to the facility on 12/04/2022, with diagnoses including Alzheimer's and dementia. Resident #10's clinical record documented a pharmacy review was completed on 05/23/2026. Resident #10's file lacked documented evidence of a prior completed pharmacy review. Resident #11 Resident #11 was admitted to the facility on 01/06/2025, with diagnoses including dementia, depression and hypertension.			

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	Resident #11's clinical record documented a pharmacy review was completed on 05/23/2026. Resident #11's file lacked documented evidence of a prior completed pharmacy review. Resident #12 Resident #12 was admitted to the facility on 02/24/2024, with diagnoses including chronic obstructive pulmonary disease (CPOD), hypertension and hypothyroidism. Resident #12's clinical record documented a pharmacy review was completed on 05/23/2026. Resident #12's file lacked documented evidence of a prior completed pharmacy review. Resident #13 Resident #13 was admitted to the facility on 07/31/2025, with diagnoses including vascular dementia and hypertension. Resident #13's record included six-month drug regimen reviews completed on 10/26/2025 and 05/21/2026. Resident #13's pharmacy review completed on 05/21/2026 was completed one month late. Resident #14 Resident #14 was admitted to the facility on 04/10/2023, with diagnoses including Alzheimer's dementia with behavioral disturbance and diabetes mellitus type two. Resident #14's record included six-month drug regimen reviews completed on 10/26/2025 and 05/21/2026. Resident #14's pharmacy review completed on 05/21/2026 was completed one month late. Resident #15 Resident #15 was admitted to the facility on 11/16/2022, with diagnoses including dementia and hypertension.			

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	Resident #15's record included six-month drug regimen reviews completed on 10/26/2025 and 05/21/2026. Resident #15's pharmacy review completed on 05/21/2026 was completed one month late. On 05/27/2026 at 1:35 PM, the Wellness Director confirmed the May 2026 pharmacy reviews were completed late and files lacked pharmacy reviews prior to 05/23/2026. On 05/27/2026 at 2:43 PM, the Memory Care Director (MCD) confirmed more than six months had elapsed between the October 2025 and May 2026 drug regimen reviews for the residents listed above. The MCD verbalized the facility switched contracted pharmacies in October 2025 and denied having been aware the medication regimen reviews were completed late. The MCD confirmed the MCD was aware of the requirement for a review to be completed every six months. The facility policy titled "Medication Services," dated 06/01/2025, documented the facility would have a medication regime review conducted by a registered nurse, pharmacist or physician who had no financial interest in the facility every six months. Severity: 2 Scope: 3			
Y 0874 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns	Y 0874	Y 0874 1. Resident #8's 6-month medication review was sent to their physician on 6-2-26 out of the 72-hour regulatory window starting Saturday, 5-23-26. (See exhibit #16) 2. We will now send all medication reviews within 72 hours of the ED signing the reviews to their physicians. We are now clear on this regulation. 3. Once the ED signs the reviews, the Resident Care Director (RCD), the Generations Program Director (GPD), and the Resident Care Coordinator (RCC) that are on duty in that 72-hour window will send the reviews to the resident physician. 3. The ED will be responsible for coordinating the reviews are sent within the	09/01/2026

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	noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on clinical document review, record review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months with recommendation from the six month medication profile review was forwarded to the resident's provider within 72 hours for 1 of 20 sampled residents reviewed for medications and residing in the facility longer than six months (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 02/06/2023, with diagnoses including cognitive deficit, atrial fibrillation, and glaucoma. Resident #8's six-month medication profile review, dated 05/21/2026 lacked the facility's notification to the resident's provider of a medication review recommendation within 72 hours On 05/27/2026 at 11:12 AM, the Administrator explained the Medication Reviews were still in the process of being sent out to the Residents' providers. Severity: 2 Scope: 1		72-hour window to physicians. 4. ED, RCD, GPD, RCC 5. Completed	
Y 0878 SS= D	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or	Y 0878	**Y 0878** 1. Resident #7 did not have Acetaminophen 500 mg or Vevye 0.1% drops on site. The Vevye 0.1% drops were delivered on 6-11-26. (See exhibit #17)and the Acetaminophen 500 mg was delivered on 5-28-26. (See exhibit #18). Resident #10 did have Ondansetron ODT UD 4mg tablets on site. (See exhibit #19) Resident #11 did have Pramoxine HCL 1% lotion on the cart with an additional two bottles in overflow. (See exhibit #20) Resident #17	09/02/2026

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	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.		had taken his last Oxycodone 5mg tablet at 1:10am the morning of 5-27-26. The med tech had called the doctor's office due to it being a controlled substance on 5-26-26. The medication was not available during the survey, but was received on 5-28-26, following insurance approval. (See exhibit#21) Resident #19 did not have a change of direction sticker on the Spironolactone 25mg. The doctor had changed to 50 mg, so the med techs were administering two pills. On 5-27-26 with the surveyors present, the 25mg was destroyed (See Exhibit #22)by the med tech and Resident Care Director (RCD) because we did have 50mg available (see Exhibit #23) and showed the surveyor. Resident #15 did not have a change of direction sticker for Xtampza ER 9 mg. The change of direction sticker was placed at the time of survey. (See exhibit #24) 2. (a) Going forward the Resident Care Director (RCD) and Generations Program Director (GPD) will instruct the NOC shift med techs to look at all prn's, and for all prn's with less than 7-day availability and report back to them immediately for ordering. 3. (b) Change of direction stickers will be placed immediately when the RCD or GPD receives an order to change a current medication. 3. Med Cart audits will continue weekly and the RCD and GPD will share their findings with the ED at their weekly 1:1. 4. ED, RCD, GPD, and NOC med techs 5. Completed	

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Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to ensure 1) medications were onsite and available to administer as prescribed for 4 of 20 sampled residents (Resident #7, #10, #11, and #17) and 2) a change order label was affixed to a medication container when the administration instructions were changed by a physician's order for 2 of 20 sampled residents (Resident #19 and #15).

Findings include:

Medications not onsite

Resident #7

Resident #7 was admitted to the facility on 04/20/2026, with diagnoses including stage 3 chronic kidney disease, atrial fibrillation, and hypertension.

Resident #7's May 2026 Medication Administration Record (MAR) documented the following medications.
-Acetaminophen 500 milligram (mg) tablet, take two tablets by mouth every morning. Medication was last administered 05/27/2026.
-Vevye 0.1% drops, instill one drop into both eyes twice daily. Medication was last administered 05/27/2026.

On 05/27/2026 at 2:36 PM, Resident #7's Acetaminophen and Vevye drops were not on-site and available to administer to the resident.

On 05/27/2026 at 2:40 PM, the Medication Technician confirmed Resident #7's Acetaminophen and Vevye drops were not on-site and available to administer to the resident and was last administered on 05/27/2026.

Resident #10

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	Resident #10 was admitted to the facility on 12/04/2022, with diagnoses including Dementia and Alzheimer's. A physician's order dated 02/12/2026, documented Ondansetron ODT UD 4 milligrams (mg) Tab Rapdis. Dissolve 1 tab sublingually every 6 hours as needed for nausea or vomiting. Resident #10's May 2026 MAR documented Ondansetron ODT UD 4 mg tab rapdis. Dissolve 1 tab sublingually every 6 hours as needed for nausea or vomiting. On 05/27/2026 at 12:25 PM, Medication Technician (MT) confirmed Ondansetron ODT UD 4 MG tab rapdis was not available on the medication cart. The MT verbalized, not knowing why it was not available. The MT confirmed Ondansetron ODT UD 4 MG tab rapdis was documented on the physician order and on the MAR. Resident #11 Resident #11 was admitted to the facility on 01/06/2025, with diagnoses including dementia, depression and hypertension. A physician's order dated 03/25/2026, documented Pramoxine HCL 1% lotion. Apply 1 application topically every day to the entire body for generalized itching. Resident #11's May 2026 MAR documented Pramoxine HCL 1% lotion. Apply 1 application topically every day to the entire body for generalized itching. On 05/27/2026 at 12:35 PM, MT confirmed Pramoxine HCL 1% lotion			

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	was not available on the medication cart. The MT confirmed Pramoxine HCl lotion 1% lotion was documented on the physician order and on the MAR. Resident #17 Resident #17 was admitted to the facility on 06/09/2025, with diagnoses including congestive heart failure and atrial fibrillation. A physician order dated 02/04/2026, and the May 2026 MAR for Resident #17 documented Oxycodone 5 mg tablet, take one tablet by mouth every 12 hours as needed. On 05/27/2026 at 12:52 PM, Oxycodone was not present on the medication cart where the remaining medications for Resident #17 were stored. The Med Tech confirmed the physician ordered Oxycodone was not onsite and available to administer. A refill had been ordered the previous night; however, the medication had not been delivered. Lack of a change label/sticker Resident #19 Resident #19 was admitted to the facility on 01/03/2026, with diagnoses including coronary artery disease and hypertension. A physician order dated 04/29/2026 and the May 2026 Medication Administration Record (MAR) for Resident #19 documented Spironolactone 50 milligram (mg) tablets. Take one tablet by mouth every day. On 05/27/2026 at 1:24 PM, a bubble pack containing Spironolactone 25 mg tablets was stored with Resident #19's medications. On 05/27/2026 at 1:24 PM, a Medication Technician (Med Tech) confirmed the 25 mg tablets did not match the ordered dose of 50 mg and verbalized a change order sticker should have been placed on the			

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	bubble pack when the order changed. Resident #15 Resident #15 was admitted to the facility on 11/16/2022, with diagnoses including dementia and hypertension. A physician order dated 04/09/2026, documented Xtampza extended release (ER) 9 mg capsule. Take one capsule by mouth every six hours as needed for moderate pain. Resident #15's May 2026 MAR, documented Xtampza ER 9 mg capsule. Take one capsule by mouth every six hours as needed for pain. On 05/27/2026 at 1:31 PM, Xtampza ER 9 mg capsules were stored with Resident #15's medications. The label on the container included instructions to take one capsule by mouth two times per day. The container and label lacked any indication the directions for administration had changed. On 05/27/2026 at 1:35 PM, a Med Tech confirmed the instructions for administration on the container of Xtampza did not match the instructions on the facility's MAR and the physician order and the container lacked a change order label/sticker. The Med Tech verbalized a change order sticker should have been placed on the medication container when the order was changed. Severity: 2 Scope: 1			
Y 0905 SS= D	**NAC 449.2746** **Administration of medication: Restriction concerning medication taken as needed by resident; written records.** 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a	Y 0905	**Y 0905** 1. Resident #18 did not have specific instructions for the administration of Acetaminophen 325mg. This has been corrected on 8-28-26. (See Exhibit #25) Resident #17 did not have instructions regarding the use of the Nicotine step One Patch 21 mg or the Oxycodone 5mg. The patch was discontinued on 8-28-26. (See exhibit #26) Resident #17 did not have an indication for the administration of Oxycodone. The Oxycodone was discontinued on 8-28-26 and the	09/01/2026

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	medication that is taken as needed unless: (a) The resident is able to determine his need for the medication; (b) The determination is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the amount of medication that may be given, and the frequency with which the medication may be given. 2. A caregiver who administers medication toa resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) 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. Inspector Comments: Based on observation, record review, and interview the facility failed to ensure an as needed (PRN) medication included written instructions indicating a specific symptom for which the medication was to be given and did not require an assessment to determine if the medication was appropriate		Oxycodone 5 mg. was discontinued as well. (See exhibit #26) Resident #16 did not have an indication for Acetaminophen 325 mg. A clarification was received on 9-1-26. (See exhibit #27) Resident #5 did not have an indication for the administration of Acetaminophen 50 mg. The prescribing physician clarified the indication on 8-28-26. (See exhibit #28) 2. Over the last three months since the survey the Resident Care Director (RCD) and Generations Program Director (GPD) have faxed providers with incomplete indications for all residents and they have all been reviewed and addressed. At the time of order receipt, the RCD and GPD will contact the provider for clear and concise indications for administration before approving/entering into our system. 3. Weekly med cart audits will continue to monitor indication compliance. The ED will be informed of non-compliance immediately. 4. ED, RCD, GPD 5. Completed	

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(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
	to administer for 4 of 20 sampled residents (Residents #18, #17, #16, and #5). Findings include: Resident #18 Resident #18 was admitted to the facility on 10/21/2023, with diagnoses including hypertension and post-polio syndrome. A physician order signed 05/06/2026 documented Acetaminophen 325 milligram (mg) tablet. Take one tablet by mouth every six hours as needed for mild pain. On 05/27/2026 at 12:44 PM, the label on a container of Acetaminophen 325 mg tablets for Resident #18 included instructions to administer one tablet every six hours as needed for mild pain. On 05/27/2026 at 12:49 PM, a Medication Technician (Med Tech) verbalized Resident #18 informed staff the resident was in pain by stating the resident had back pain. The Med Tech confirmed the instructions for administration of Acetaminophen indicated the medication was to be given for mild pain. The Med Tech verbalized mild pain included a headache and back pain. Facility staff would enter a number from 0-10 in the electronic MAR when a resident was in pain and the Med Tech verbalized the Med Tech believed a pain rating of 1-5 was considered mild. The Med Tech denied having instruction from the physician to indicate what pain rating was considered mild pain. Resident #17 Resident #17 was admitted to the facility on 06/09/2025, with diagnoses including congestive heart failure and atrial fibrillation. A physician order dated 11/21/2025 documented Nicotine step one patch 21 mg, 24-hour patch. Apply one patch to skin every day as needed. A physician order dated 02/04/2026 and the May 2026 MAR for Resident #17 documented Oxycodone 5 mg tablet, take			

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	12218	A. BUILDING _____ B. WING _____	05/27/2026

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	one tablet by mouth every 12 hours as needed. On 05/27/2026 at 12:52 PM, a box of Nicotine patches was stored with Resident #17's medications. The label on the box included instructions to apply one patch to skin every day as needed. The instructions lacked a specific symptom for which to administer the medication. On 05/27/2026 at 1:03 PM, a Med Tech confirmed the PRN Nicotine patches for Resident #17 lacked an indication for administration. On 05/27/2026 at 1:07 PM, the Wellness Director (WD) verbalized the facility could not enter orders into the electronic MAR (eMAR) without a reason for use. The WD accessed Resident #17's eMAR and showed the surveyor a text box labeled "reason for use". The reason for use for Oxycodone was pain and the reason for the Nicotine patches was smoking cessation. The WD explained the text box was filled in by facility staff at the time the order was entered into the eMAR. On 05/27/2026 at approximately 1:10 PM, the WD reviewed the physician orders for Oxycodone and Nicotine patches for Resident #17, confirmed the orders lacked an indication for administration and confirmed the indication entered in the eMAR for the PRN medications should have come from the prescriber. Resident #16 Resident #16 was admitted to the facility on 02/16/2025, with diagnoses including dementia and coronary artery disease. A physician order signed on 02/19/2026 and the May 2026 MAR for Resident #16 documented acetaminophen 325 mg tablet. Take two tablets by mouth every four hours as needed for mild pain or fever. On 05/27/2026 at 1:15 PM, a Med Tech confirmed the indication for acetaminophen for Resident #16 was mild pain or fever.			

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	The Med Tech verbalized the Med Tech thought a fever was a temperature of 100 and explained the Med Tech would use google to look up what temperature was considered a fever. Resident #5 Resident #5 was admitted to the facility on 01/12/2023, with diagnoses including Alzheimer's disease, glaucoma, and low back pain. A physician order dated 05/06/2026 and the May 2026 MAR for Resident #5 documented Acetaminophen 500 mg tablet. Take one tablet by mouth four times a day as needed for mild pain. On 05/27/2026 at 1:18 PM, the Med Tech confirmed the indication for administration of Acetaminophen for Resident #5 was mild pain. The Med Tech confirmed facility staff determining if a resident's pain was mild, moderate, or severe was considered an assessment and denied Med Techs were able to assess. 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	Y 0920	Y 0920 1. Resident #15 did not have a label with the prescribing physician and resident name on Centrum Silver. The label was completed on 5-27-26. (See exhibit #29) Resident #15 did not have the prescribing physician and resident name on Bio Complete 3 Probiotics 1000 mg. The label was completed on 5-27-26. (See Exhibit #30) Resident #5 did not have her unopened Latanoprost eye drops refrigerated. The eye drops were immediately placed in the refrigerator with the surveyor present. In apartment 224 the self medication resident did not have their medications locked up. The meds were locked up on 5-27-26 in their lockbox with the surveyor present. In apartment 239, the self medication resident did not have their meds locked up. The meds were locked up on 5-27-26 in their lockbox. 2. On 7-10-25 , the community had locks installed in all apartments bathrooms where residents	07/10/2026

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	resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication 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, record review and document review, the facility failed to ensure 1) an over-the-counter (OTC) medication was labeled with the prescriber's name and/or the resident's name for whom the medication was prescribed for 2 of 20 sampled residents (Resident #7 and 15); 2) a medication was stored according to manufacturer and pharmacy instructions for 1 of 20 sampled residents (Resident #5); and 3) residents' medications were stored securely for 2 of 15 residents who self-administered medication. Findings include: OTC labeling Resident #7		perform self medication. (See exhibit #31, 32, and 33) 3. Going forward we will continue to conduct room checks for unsecured medications. Upon finding unsecured medications, the resident and their family will be advised of non-compliance. 4. ED, Resident Care Director, Generations Program Director, and Resident Care Coordinator 5. Completed	

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	Resident #7 was admitted to the facility on 04/20/2026, with diagnoses including stage 3 chronic kidney disease, atrial fibrillation, and hypertension. A physician order dated 04/14/2026, documented Centrum Silver tablet, take one tablet by mouth every day. On 05/27/2026 at 2:36 PM, the Centrum Silver tablet bottle located in the medication cart for Resident #7, lacked a label documenting the resident's name and the name of the physician who ordered the medication. On 05/27/2026 at 2:40 PM, the Medication Technician confirmed the Centrum Silver bottle was for Resident #7. The Medication Technician confirmed the medication bottle should have had a label documenting the resident and physician names, but it did not. Resident #15 Resident #15 was admitted to the facility on 11/16/2022, with diagnoses including dementia and hypertension. The May 2026 Medication Administration Record (MAR) for Resident #15 documented Bio Complete 3 Probiotics 1000 milligram (mg) capsule. Give two capsules by mouth before a meal twice daily. On 05/27/2026 at 1:31 PM, an OTC bottle of Bio Complete 3 Probiotic 1000 mg capsules was stored with Resident #15's medications. The bottle lacked the name of the prescriber who had ordered the medication. On 05/27/2026 at 1:35 PM, a Medication Technician (Med Tech) confirmed the bottle of Bio Complete 3 Probiotic capsules lacked the name of the prescriber as required. Medication not stored according to manufacturer instructions Resident #5			

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	Resident #5 was admitted to the facility on 01/12/2023, with diagnoses including Alzheimer's disease, glaucoma, and low back pain. A physician order dated 05/06/2026 documented Latanoprost 0.005% drops. Instill one drop into both eyes every day. On 05/27/2026 at 1:18 PM, an unopened bottle of Latanoprost eye drops was stored with Resident #5's medications in a medication storage cart. The cart was not refrigerated. The bottle of Latanoprost eye drops included instructions to refrigerate the medication until opened. On 05/27/2026 at approximately 1:20 PM, the Med Tech confirmed the bottle of Latanoprost was unopened and stored in the medication storage cart. The Med Tech confirmed the bottle included instructions to refrigerate until opened and confirmed the medication cart was not refrigerated. Medication Secured On 03/19/2026, the following resident rooms contained unsecured medication: - at 11:22 AM, in Room A224, a resident who self-administered medication shared the room with a resident who did not self-administer medication. The resident who self-administered medication was present in the room and verbalized medications were kept in a cardboard box in the bedroom closet. - at 11:29 AM, in Room A239, a resident who self-administered medication shared the room with a resident who did not self-administer medication. The resident who self-administered medication was present in the room and verbalized medications were kept on a desk. The resident verbalized the medications were not secured when the other resident was in the room. On 05/27/2026 at 11:22 AM and 11:29 AM, the Generations Program Director confirmed the medications were not secured.			

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	The facility policy titled "Medication Storage – Centrally Stored Medications," dated 06/01/2025, documented all medications were to be stored in accordance with the label instructions (refrigerate, room temperature, out of direct sunlight, etc.). State regulation references included Nevada Administrative Code (NAC) 449.2748 and documented medication, including, without limitation, any over-the-counter medication or dietary supplement must be plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician. 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: (a) The full name, address, date of birth and social security number of the resident.	Y 0930	**Y 0930** 1. During the survey, the Resident Care Director gave the surveyor a copy of the positive Quantiferon test and negative check x-ray for Resident #7. The paperwork was found off to the side after the surveyors had exited. (See exhibit #34) Resident #7 had their compliant tb test. Resident #9 was hospitalized during her tb due date. The resident had their tb test completed on 2-5-26 when they returned to the community. The test was late. (See exhibit #35) Resident #13 was due on 2-17 -26 and hospice did not administer the test stating the Signs and Symptoms form was adequate, which we know to be incorrect. Resident #13 passed away on 5-27-26, the day of survey, so a test was not administered. 2. The Resident Care Director (RCD) and Generations Program Director (GPD) will continue to use their tracker/tickler for upcoming tb tests, giving two months notice to the resident, family, and provider, including weekly reminders. (See exhibit #12) 3. TB tests that are one month away with no progress are discussed at weekly 1:1 and daily standup. The family will be advised to reach out to the provider to remain compliant. 4. ED, RCD, GPD 5. Completed	09/01/2026

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	(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. (g) An evaluation of the resident's ability to perform the activities of daily living and a			

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	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 location to which the resident was transferred or the person in whose care the resident was			

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	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 clinical record review and interview, the facility failed to ensure 3 of 20 residents (Resident #7, #9, and #13) met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A. Findings include: Resident #7 Resident #7 was admitted to the facility on 04/20/2026, with diagnoses including stage 3 chronic kidney disease, atrial fibrillation, and hypertension. Resident #7's clinical record documented an initial positive QuantiFERON TB test on 02/02/2026. Resident #7's clinical record lacked documented evidence of a negative chest x-ray completed. On 05/27/2026 at 1:45 PM, the Wellness Director confirmed the facility did not have a negative chest x-ray completed upon			

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	admission. Resident #9 Resident #9 was admitted on 02/19/2025, with diagnoses including malnutrition, anxiety, and cognitive communication impairment. Resident #9's clinical record documented an initial two step TB test. The first step was administered on an unknown date and read negative on 12/22/2024. The second step was administered on an unknown date and read negative on 01/11/2025. The annual TB test was administered on 02/05/2026 and read negative on 02/08/2026. On 05/29/2026 at 2:59 PM, the Wellness Director verbalized the initial two step TB test lacking an administration date and the annual TB test was completed late. Resident #13 Resident #13 was admitted to the facility on 07/31/2025, with diagnoses including vascular dementia and hypertension. Resident #13's record included documentation of a Quantiferon Gold TB laboratory test completed on 02/17/2025. The record lacked documented evidence of the completion of an annual TB test for 2026. On 05/27/2026 at 2:43 PM, the Memory Care Director (MCD) reviewed Resident #13's record and verbalized the MCD could not locate documentation of an annual TB test having been completed for 2026. The MCD explained the MCD thought the resident's hospice provider may have completed the testing and the MCD would reach out to hospice. The facility failed to provide documented evidence of the completion of annual TB testing for Resident #13 prior to the end of the survey. Severity: 2 Scope: 1			

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Y 1540 SS= D	**NAC 449.011931and R004-24** NAC 449.011931 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended	Y 1540	**Y 1540** 1. Employee #14 completed their Cultural Competency on 11-28-25 with a re-hire date of 7-27-25. Employee #14's training was late. (See exhibit #36) Employee #15 completed their Cultural Competency training on 8-6-25, their hire date. (See exhibit #37)The training was not late. 2. There is an employee tracker in place to ensure that required trainings are compliant. (See exhibit #2) In addition to the tracker, the Business Office Manager (BOM) has been instructed to audit 10-12 employee files each week and compare each file to the tracker for compliance. This audit will result in all employee files being audited on a monthly basis. 3. The BOM will report to the ED at their weekly 1:1 about Cultural Competency training compliance. 4. ED and BOM 5. Completed	09/01/2026

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	by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on record review and interview, the facility failed to ensure cultural competency training was completed timely for 2 of 15 sampled employees required to obtain cultural competency training (Employee #14 and #15). Findings include: On 05/27/2026 at 10:54 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 04/30/2026 at 2:51 PM, the Administrator provided the completed form with the following information: Employee #14 Employee #14 was hired by the facility as Medication Technician with a start date of 03/17/2025. Employee #14's personnel file contained a cultural competency training certificate dated 11/26/2025, greater than 90 days after hire. Employee #15 Employee #15 was hired by the facility as Care Manager with a start date of 07/27/2025. Employee #15's personnel file contained a cultural competency training certificate dated 11/28/2025, greater than 90 days			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12218	A. BUILDING _____ B. WING _____	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KILEY RANCH SENIOR LIVING	6300 DAVID ALLEN PARKWAY, SPARKS, NEVADA ,89436

(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
	after hire. On 05/27/2026 at 2:55 PM, the Administrator provided the Attestation of Compliance form, signed and dated 05/27/2026, confirming the Administrator had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
Y 1840 SS= F	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on interview and personnel record review, the facility failed to ensure evidence-based infection prevention training was provided by a nationally recognized organization	Y 1840	**Y1840** 1. Employee #2, 10, 11, and 14 have completed their Infection Control video/quiz training. (See exhibit #38, 39, 40, and 41) During the survey, it was noted that a 15-minute Infection Control video and quiz approved by the state needed to be completed by all employees in the community. The ED contacted the Infection Control Preventionists at the State of Nevada who came out in June 2026 to assess the community, provide a compliant Infection Control Plan (See exhibit #42), and provide the website for the video/quiz training requirement. After receiving the website, the community had employees provide their current personal emails to register and take the training. To date, we have 60 of 62 employees who have completed the training. 2. At the time of hire, all new employees will be sent the link to their personal email to register and take the training with a time limit for completion. 3. Another column has been added to the employee tracker for tracking purposes. (See exhibit #2) 4. ED and Business Office Manager 5. Completed, but ongoing with remaining staff and new hires to complete which does not affect the completion of this tag.	10/31/2026

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	12218	A. BUILDING _____ B. WING _____	05/27/2026

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	concerning the control of infectious diseases, for unlicensed caregivers, for 4 of 4 unlicensed caregivers working at the facility greater than one year (Employee #2, #10, #11, and #14). Findings include: On 05/27/2026 at 10:54 AM, the Administrator was provided the Personnel Check List to complete for 15 sampled employees. On 04/30/2026 at 2:51 PM, the Administrator provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Resident Care Director with a start date of 09/26/2023. Employee #2's personnel file lacked documented evidence of infection prevention training for unlicensed caregivers. Employee #10 Employee #10 was hired by the facility as Care Manager with a start date of 05/08/2025. Employee #10's personnel file lacked documented evidence of infection prevention training for unlicensed caregivers. Employee #11 Employee #11 was hired by the facility as Care Manager with a start date of 12/27/2024. Employee #11's personnel file lacked documented evidence of infection prevention training for unlicensed caregivers. Employee #14 Employee #14 was hired by the facility as Medication Technician with a start date of 03/17/2025.			

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	12218	A. BUILDING _____ B. WING _____	05/27/2026

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	Employee #14's personnel file lacked documented evidence of infection prevention training for unlicensed caregivers. On 05/27/2026 at 2:55 PM, the Administrator provided the Attestation of Compliance form, signed and dated 05/27/2026, confirming the Administrator had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Administrator verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			