STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12352	A. BUILDING _____ B. WING _____	08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME	5820 W DESERT INN RD, LAS VEGAS, NEVADA ,89146

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12352	A. BUILDING _____ B. WING _____	08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME	5820 W DESERT INN RD, LAS VEGAS, NEVADA ,89146

(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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 08/25/26. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, five Category I residents and five Category II. The census at the time of survey was three. Three resident files and four employee files were reviewed. The following regulatory deficiencies were identified.			
Y 0890 SS= C	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	Y 0890	**Corrective Action Taken** On 08/25/2026, all MARs were immediately updated to reflect **specificadministration times** (e.g., 8:00 AM, 2:00 PM, 8:00 PM) instead of generaltime blocks. The House Manager corrected all entries and verified accuracy foreach resident. **Systemic Prevention Measures** 1. **MAR Formatting Standardized (Effective 08/25/2026)** All MARs will now require exact administration times for every scheduled medication. “AM/PM/HS” will no longer be permitted. 2. **Monthly MAR Audit** The Administrator will review all MARs at the start of each month to ensure specific times are documented. 3. **Staff Retraining Completed 08/25/2026** All caregivers received refresher training on NAC 449.2744 requirements, including: ◦ Proper MAR time	08/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12352	A. BUILDING _____ B. WING _____	08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME	5820 W DESERT INN RD, LAS VEGAS, NEVADA ,89146

(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
	was administered; (3) The date and time that a resident refuses, or otherwise misses, an 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 observation, document review and interview, the facility failed to ensure administration times were documented on the Medication Administration Record (MAR). Findings include: On 08/25/26 in the morning, the MAR documented administration times as		documentation ◦ Accuracy of routine and PRN entries ◦ Recording refusals, missed doses, and errors 4. **Ongoing Monitoring** Weekly MAR spot checks will be conducted for 60 days, then monthly thereafter. **Responsible Partys** Administrator/Group Home Manager **Completion Date** 08/25/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12352	A. BUILDING _____ B. WING _____	08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME	5820 W DESERT INN RD, LAS VEGAS, NEVADA ,89146

(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
	AM, PM and HS, and there were not specific times listed. On 08/25/26 in the morning, the House Manager confirmed the documentation of AM, PM and HS on the MAR and there were not specific times listed. Severity: 1 Scope: 3			
Y 0920 SS= F	NAC 449.2748 Medication Storage. 1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication 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	Y 0920	**Corrective Action Taken** On 08/25/2026 at 10:40 AM, all insulin pens (Novolog andLantus) were immediately placed inside the refrigerator's medication lock box.The lock box was secured, and the House Manager verified proper locking. **Systemic Prevention Measures** 1. **Medication Storage Policy Reinforced (Effective 08/25/2026)** All refrigerated medications must be stored in the locked medication box. External-use medications remain stored separately per NAC 449.2748. 2. **Daily Refrigerator Security Check** Caregivers will check the refrigerator lock box at the start of each shift to ensure: ◦ Box is locked ◦ All refrigerated medications are inside ◦ No medications are left unsecured 3. **Staff Retraining Completed 08/25/2026** Caregivers were retrained on: ◦ NAC 449.2748 medication security requirements ◦ Proper storage of insulin and other high-risk medications ◦ Preventing unauthorized access 4. **Weekly Storage Audits** The Administrator will conduct weekly	08/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12352	A. BUILDING _____ B. WING _____	08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON HOME	5820 W DESERT INN RD, LAS VEGAS, NEVADA ,89146

(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
	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 and interview, the facility failed to ensure medications were secure. Findings include: On 08/25/26 at 10:40 AM, observed four Novolog 100 unit/milliliter (ml) flex pens, and three Lantus Solostar 100 unit pens on a shelf in the facility refrigerator. The medication lock box in the refrigerator was empty and unlocked. On 08/25/26 at 10:40 AM, the House Manager confirmed the observation of the unsecured insulin pens in the refrigerator. The House Manager explained the insulin pens were for a discharged resident and that a nurse would discard the insulin pens. Severity: 2 Scope: 3		audits for 60 days, then monthly thereafter. **Responsible Partys** Administrator/Group Home Manager **Completion Date** 08/25/2026	