Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2175	A. BUILDING _____ B. WING _____	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS SENIOR RESIDENCE	5935 W SADDLE AVE, LAS VEGAS, NEVADA ,89103

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 06/24/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was four. Four resident files and four employee files were reviewed. The facility received a grade of B. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure an annual tuberculin (TB) test was conducted for 1 of 4 employees (Employee #1). Findings include: Employee #1 (E1) E1 was hired on 07/10/21 as a Caregiver. E1's file documented an annual one-step TB test on 05/07/24. E1's employee file lacked documented evidence of an annual TB test in 2025. On 06/24/25 in the afternoon, the Owner acknowledged the documentation could not be found in E1's employee file and could not provide an annual TB test to prove E1 had an annual TB test. Severity: 2 Scope: 1	0102	Tag# Y0102 Employee Annual TB The Administrator along with the owner will make a spread sheet to ensure an accurate time frame for all compliances. See attached. With this Compliance sheet there will be no missed annual TB's for any employees. Corrective action was done on 6-25-2025.	08/11/2025

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: WENDY RAMIREZ Title: ADMINISTRATOR Date: 09/30/2025

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0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 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.; Inspector Comments: Based on record review and interview, the facility failed to develop a person-centered service plan for 4 of 4 residents (Residents #1, #2, #3, and #4). Findings include: Resident #1 (R1) R1 was admitted on 06/17/25 with diagnoses including Alzheimer's Disease, Chronic Kidney Disease and hypertension. R1's file lacked documented evidence of a person-centered service plan. Resident #2 (R2) R2 was admitted on 11/26/24 with diagnoses including chronic obstructive pulmonary disease (COPD), cardiovascular accident (CVA), and hypertension. R2's file lacked documented evidence of a person-centered service plan. Resident #3 (R3) R3 was admitted on 10/17/24 with diagnoses including history of falling and forgetful/cognitive. R3's file lacked documented evidence of a person-centered service plan. Resident #4 (R4) R4 was admitted on 05/03/24 with diagnoses including hypertension, neurocognitive disorder and unspecified dementia. R4's file contained a person-centered service plan dated 05/03/24. R4's file lacked documented evidence of a current person-centered service plan. On 06/24/25 in the afternoon, the Administrator acknowledged person-centered service plans were not developed for R1, R2, and R3, and R4's person-centered service plan was not reviewed annually. Severity: 2 Scope: 3	0515	Tag Y0515 Person Centered Care Plan Upon admission the resident will have a Person Centered Care Plan put together by the Administrator or the owner. The staff will be aware of the residents choices and be sure to follow through on what the plan states. All Resident's will be involved with this plan along with a family member is needed. The PCCP will be located in the residents file for any reference that's needed by staff. This corrective action was done on 6-29-2025.	09/02/2025
0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may	0830	Tag Y0830 Exempt Waiver The administrator will be sure to assist in all intakes before the resident begins move in.	08/11/2025

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	submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure a medical exemption request was submitted to the Bureau prior to admitting 1 of 4 residents who required Foley catheter care (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 06/17/25 with diagnoses including Alzheimer's Disease, Chronic Kidney Disease Stage 3, and hypertension. On 06/24/25 in the morning, R1 was observed to have a Foley catheter. R1 was unable to care for the Foley catheter on their own. On 06/24/25 in the morning, the Administrator explained the facility was doing R1's hospice company a favor because R1 had been living at their own personal residence with their Power of Attorney (POA) as their caregiver, and when the POA/caregiver had to be admitted at the hospital, R1 came to do a respite stay at the facility. R1's post-acute facility Order Summary Report dated 06/17/25 documented Indwelling Urinary (Foley) catheter care: cleanse with soap and water every shift, order date 06/12/25. A progress note dated 06/17/25 from this facility documented: The hospice company contacted our facility with the consent of the Power of Attorney (POA), and asked for the favor for R1 to reside at the facility for at least one month. R1 was under the services of the hospice company 2-3 times a week with a visiting Registered Nurse who was on call 24/7 if necessary, and with Certified Nursing Assistant (CNA) care for for five days for R1. The facility lacked documented evidence of a medical waiver for R1's Foley catheter. On 06/24/25 in the morning, Employee #2 (E2), a Caregiver, explained the facility emptied the catheter bag twice a day. E2 and Employee #1 (E1) had documented Foley catheter training in their files. On 06/24/25, the Certified Nursing Assistant (CNA) from R1's hospice company verbalized the hospice nurse		If there is any indication that a Waiver must be had, then the administrator will apply for it immediately. No one will be admitted without the Waiver. resident no longer resides at the residence.	

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	changed the catheter bag. On 06/24/25 in the morning, the Administrator acknowledged the facility had not applied for a medical exemption to admit and retain R1 due to their Foley catheter, and explained R1 would be discharged back to home soon when R1's home caregiver was discharged from the hospital. Severity: 2 Scope: 1			
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were out of the reach of residents. Findings include: On 06/24/25 in the morning, the following items were observed under the kitchen sink, in an unsecured cabinet: -Powdered Bleach Cleaner -Carpet Cleaner -All-Purpose Cleaner -Concentrated Cleaner -Insect Killer -Bathroom Cleaner -Bedbug and Flea Fogger -Automatic Dishwasher Powder -Furniture Polish On 06/24/25 at 10:00 AM, the Employee #2 (E2) acknowledged the toxic substances and reported they would talk to the maintenance person about installing a lock on the cabinet door. Severity: 2 Scope: 3	0999	Tag Y0999 Toxins The staff will be instructed to store all chemicals in a safe and locked cabinet. The residents will not have any access to any of these chemicals at any time. All the staff will unlock the supply cabinet when they are needing supplies, then relock when done. Nothing else will be store in this cabinet. The administrator will check on this as well as the owner to ensure it is always locked. If necessary cabinets are needed the GH can installed an additional cabinet. The corrective action was done on 6-29-2025.	06/24/2025
1825 SS= E	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is	1825	Tag Y1825 Infection Control The administrator along with the Owner will ensure all employee training is done before their training expires. All employees must be aware that their training does expire and can refer to the compliance sheet for the date of expiration. Any training expired for the employee will be taken off the schedule until training is received with an certificate. The corrective action was done on 6-24-2025.	09/02/2025

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	responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control staff completed 15 hours of infection control training annually (Employees #3 and #4). Findings include: Employee #3 (E3) E3 was hired as the Administrator on 06/28/17. On 06/24/25 in the afternoon, E3 was identified as the current primary infection control person for the facility. E3's file contained documented evidence of 15 hours of approved infection control training completed on 05/31/24. E3's training expired on 05/31/25. E3's file lacked documented evidence of 15 hours of approved infection control training completed annually. Employee #4 (E4) E4 was hired as the Owner/Caregiver on 03/12/03. On 06/24/25 in the afternoon, E4 was identified as the current secondary infection control person for the facility. E4's file contained documented evidence of 15 hours of approved infection control training completed on 05/29/24. E4's training expired on 05/29/25. E4's file lacked documented evidence of 15 hours of annual infection control training regarding the			

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	control and prevention of infections from an approved organization. On 06/24/25 in the afternoon, the Owner acknowledged E3 and E4's infection control training had expired, and both E3 and E4 needed to complete at least 15 hours of approved infection control training in 2025. Severity: 2 Scope: 2			
1840 SS= D	UNL Caregiver Training - R063-21 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 record review and interview, the facility failed to ensure 1 of 4 Caregivers completed the annual required infection control training for unlicensed caregivers (Employee #1). Findings include: Employee #1 (E1) E1 was hired as a Caregiver on 07/10/21. E1's file lacked documented evidence of the required infection control training provided by a nationally recognized organization. On 06/24/25 in the afternoon, the Owner confirmed E1 did not complete the required annual infection control and prevention training. Severity: 2 Scope: 1	1840	Tag Y1840 Caregiving Training. The administrator along with the staff will be in compliance with any and all training. The annual training log will be updated as needed so all staff are aware what is coming due for training. The corrective action was a completed on 8-11-2025. Attached is the certoficate.	06/24/2025