DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ASSISTED LIVING AT HENDERSON	**1050 E LAKE MEAD PARKWAY, HENDERSON, NEVADA ,89015**

(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, complaint and facility reported incident (FRI) State Licensure survey completed in your facility on 03/27/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 70 Residential Facility for Group beds for elderly and/or disabled persons and/or persons with mental illness and/or persons with intellectual disabilities and/or persons with Alzheimer's disease, and provides assisted living services, Category II residents. The census at the time of survey was 50. Fifteen resident files and ten employee files were reviewed. The facility received a grade of D. There was one complaint investigated and one FRI investigated. Substantiated: 1. Complaint# NV00070621 was substantiated. (See TAGS Y0178, Y853 Y0878, Y991, Y994 and Y999) 2. FRI #9237 was substantiated with no deficient practice. The investigation of Complaint and FRI included: Observation of grooming and physical appearance of residents, a resident's recliner, meal observation, the elevator, and a tour of the facility including the memory care. Interviews were conducted with residents, Caregivers, Mediation Technician, Resident Care Coordinator, Expressions Director, Resident Services Director, and the Administrator. Record Review of six records, which included the residents of concern. Document Review included facility policy and procedures, medication destruction log, incident reports, special diet log. 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 investigation, 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JAMES A. COX Title: Administrator Date: 05/13/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on record review and interview, the facility failed to ensure annual caregiver training was completed for 1 of 10 employees (Employee #5). Findings include: Employee #5 (E5) E5 was hired on 08/13/2023 as a Caregiver. E5's file lacked documented evidence of 8 hours of annual caregiver training. On 03/27/2024 in the afternoon, the Acting Administrator acknowledged that E5's file lacked documented evidence of annual caregiver training. Severity: 2 Scope: 1	0065	(Please be advised that employee # 5 is no longer with the company) The administrator and or its designees will ensure that all employees complete 8 hours of specific tier 1 and tier 2 training for the needs of the elderly/disabled within 60 days of hire and annual thereafter. The administrator or its designees will ensure that all employees have met this requirement through online training on/or monthly in person in-services. The administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	04/30/2024
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure	0074	(please be advised that employee # 5 & employee #10 are no longer with the company) Employee #2 Certificate of completion is	04/30/2024

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	to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual		attached. The administrator and/or its designee will ensure the Elder Abuse Training will occur prior to any employee beginning any care to a resident at Prestige Assisted Living of Henderson and provided annually thereafter. Training will consist of a self-paced training module approved of by the State of Nevada Aging and Disability Services Division or its designee. Proof of training will be provided of at least 85% and a certificate of completion will be issued and retained in the employee's training file. Test compliance will be scored by the office manager, administrator or designee. The office manager, administrator or designee will audit employee files periodically, to ensure regulatory compliance. The administrator is responsible to ensure compliance. Date of compliance 04/30/2024	

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	residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home,			

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	facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review and interview, the facility failed to ensure initial elder abuse training was completed for 2 of 10 employees (Employee #2 and #5), and annual elder abuse training was completed for 1 of 10 employees (Employee #10). Findings include: Employee #2 (E2) E2 was hired on 05/31/2023 as the Life Enrichment Director. E2's file lacked documented evidence of training to recognize and prevent abuse of older persons. Employee #5 (E5) E5 was hired on 08/13/2023 as a Medication Technician. E5's file lacked documented evidence of training to recognize and prevent abuse of older persons. Employee #10 (E10) E10 was hired on 04/05/2022 as a Personal Care Attendant. E10 completed initial elder abuse training on 04/05/2022. E10's file lacked documented evidence of annual elder abuse training for 2023. On 03/27/2024 in the afternoon, the Acting Administrator acknowledged E2 and E5 had not completed initial elder abuse training, and E10 had not completed annual elder abuse training. Severity: 2 Scope: 2			

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 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: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure an "Undetermined" result through the Nevada Automated Background Check System (NABS) was followed up on for 1 of 10 employees (Employee #10). Findings include: Employee #10 (E10) E10 was hired on 04/05/2022 as a Personal Care Attendant. E10's file lacked documented evidence of a completed background check. A search of NABS revealed E10 had fingerprints taken on 3/30/2022 showing the determinate status as "Undetermined." E10's file lacked documented evidence of a final NABS clearance letter and lacked evidence that the facility followed up on the "Undetermined" status of the background check. On 03/27/2024 in the afternoon, the Acting Administrator acknowledged a background check was not completed and no follow up of the Undetermined result for E10. Severity: 2 Scope: 1	0104	(Employee #10 is no longer with the company) The administrator and/or its designee will ensure that NABS is completed for all employees and any "Undetermined" status are followed up on within the established time frame. If clearance is not obtained from the state, employee will be removed from the schedule until remedied. The administrator will be responsible for compliance. Date of compliance 4/30/2024	04/30/2024
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises was clean and an exit door in the memory care unit and an elevator were repaired and well maintained. Findings include: The following observations were made on 03/27/24 in the morning: - An exit door in the memory care failed to lock	0178	ON 04/26/2024 the Memory Care door was repaired by FASTEC/Vortex company in accordance with NV NRS compliance and NV State Fire code. A good faith payment has been made by Prestige Assited Living of Henderson of $42,900.30 to KONE Elevators of Pasadena for the replacement of the main elevator. Total cost $158,890. As noted, the work will begin on or before June 2024. Residents and staff of PALH have been reminded and informed that any issues with the elevator should be reported to the concierge, Executive Director or any management staff for remedy. Any residents or staff stuck in the elevator that cannot be re-set or returned, safely to the	04/30/2024

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	properly. There was a chair in front of the door to keep memory care residents from exiting out of the broken door. - The facility elevator was found to be slow, but operational while onsite. - The carpet was observed to be stained and worn in several places, and the walls had a few dents which needed repaired. - There was a large accumulation of bird guano underneath a table on the patio in back of the facility which was accessible to residents. - At 11:10 AM, there was no hand soap in the hallway bathroom across from Room 205. On 03/27/24 in the morning, a family member of Resident #18 verbalized that the elevator breaks down about once a month and it would be nice if the facility would fix it. On 03/27/24 in the morning, Resident #17 reported the elevator has had some maintenance issues and some unknown residents have been stuck in the elevator briefly. On 03/27/24 at 10:33 AM, a Caregiver reported the staff had been reporting the broken exit door in the Memory Care unit for 4 to 5 months. On 03/27/24 in the morning, two caregivers and the Resident Care Coordinator reported a resident had eloped out of the broken memory care door. The Resident Care Coordinator reported the elevator was old and was aware of residents being stuck in there previously. There were no reported injuries. On 03/27/24 in the morning, the Operations Systems Specialist acknowledged the elevator was not consistently working correctly, and the memory care exit door was broken. The Operations Systems Specialist verbalized the parts were on backorder and were scheduled to be repaired in June 2024. Although the facility had parts on back order with repairs scheduled for June 2024, the facility lacked a plan to keep residents from getting stuck in the elevator and the only deterrent they had for the broken memory care door was a chair placed in front of it. The Maintenance Director acknowledged the elevator and broken memory care door		first floor, 911 will be called and emergency services will assist with the evacuation of the elevator car. The reported bird guano, damaged walls, stained carpet and lack of hand soap have all been cleaned, repaired, and/or replaced as of 4/30/2024. Please see attached photos as proof the work has been completed. The administrator and/or its designee along with the Maintenance Director will ensure that cleanliness of the community is maintained at a high level of cleanliness and operational safety through daily walk throughs, TELS preventative maintenance service scheduling and resident and staff reporting. The Administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	

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	were not fully operational. On 03/27/24 in the morning, the Maintenance Director acknowledged the stained carpet, dents in walls, bird guano, and lack of hand soap in the public bathroom, and the housekeeping staff should keep hand soap in the bathrooms at all times. Severity: 2 Scope: 3 Complaint# NV00070621			

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0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 03/27/2024, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. A countertop deep fat fryer was stored on a cart by the three-compartment sink. The Dietary Manager indicated the fryer was placed on top of the griddle on the cook's line when the fryer was in use. The cook's line ventilation hood Ansul Fire Suppression system was not designed/approved for a deep fat fryer; and the griddle was not an approved surface to operate the deep fat fryer on. b. Non-food contact surfaces in the main kitchen were soiled with grease, food debris, and/or dust build-up on the cook's line ventilation hood filters, around the conveyor toaster and the interior of the microwave. c. Non-food contact surfaces in the memory care serving kitchen were soiled with food and debris in the interior of the microwave and the inside of the non-commercial cabinetry. d. There was no soap provided at the hand washing sink in the back of the kitchen. There was no soap or paper towels provided at the hand washing sink in the memory care serving kitchen. e. The floors in the kitchen were soiled with food and debris under the soiled dish table by the dish machine and underneath preparation tables. Severity: 2 Scope: 2	0255	The deep fat fryer has been permanently removed from service and the menus changed to reflect that meal option. The administrator and/or Dietary Manager will maintain and ensure that this is never an option under current kitchen concept. The kitchen has reimplemented its routine cleaning schedule (attached) and contracted with a local vendor to clean on a routine basis the non food contact surfaces in the ventilation hood. Additionally, the surfaces in and around the microwave and toaster have been cleaned, as have the cabinets and memory care serving areas. Soap and paper towels are part of a daily checks list to ensure proper hygiene products are available and used. Kitchen floors have been cleaned and are now on a routine, daily clean. The administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	04/30/2024
0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical	0853	On March 28,2024 an All Team Meeting was held at Prestige Assisted Living of Henderson for staff to review the established policy and procedure for a	04/30/2024

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	care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (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. Inspector Comments: Based on record review and interview, the facility failed to ensure an incident report was completed by staff when residents eloped from the facility for 2 of 16 sampled residents (Resident #14 and #16). Findings include: Resident #14 (R14) R14 was admitted to the facility on 01/13/23 with diagnoses of dementia and hypertension. On 03/27/24 in the morning, two Caregivers reported R14 eloped through the broken exit door in the memory care unit several months ago at 5:30 AM. On 03/27/24 in the morning, the Resident Care Coordinator confirmed being informed by a caregiver that R14 had eloped from the facility. The Resident Care Coordinator acknowledged there was no incident report documenting R14's elopement through the broken exit door. Resident #16 (R16) R16 was admitted to the facility on 06/13/22 with diagnoses of dementia and anxiety disorder. On 03/27/24 in the morning, the Resident Care Coordinator verbalized they were notified of R16 eloping from the facility while they were on vacation via text message on 01/12/24. The Resident Care Coordinator confirmed there was no incident report documenting R16's elopement on 01/12/24. On 03/27/24 in the		missing person, reporting of said person and the documentation required after the incident. Please see attached in-service sign in sheet, policy on elopement and wandering as well as sentinel reporting and incident reports. Also discussed at this meeting was the review of resident counts, and what to do in the event of a malfunction on the memory care door, until repaired. Please see attached Incident Reports for Resident 14 LB and Resident #16 JA The administrator and/or its designee will review on a daily basis the events of the previous day, same day and or upon incident that proper documentation and reporting have been completed per Prestige policy and procedure. The administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	

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	morning, the Operations Systems Specialist indicated the process was for the facility to complete an incident report report when a resident eloped from the facility. Facility Sentinel Events Mandatory Reporting Policy and Procedure dated 05/21 documented the Sentinel event attempted and/or successful elopement of any resident required an incident report to be completed in the Electronic Health Record (EHR) System per the Incident Policy and Procedure. Severity: 2 Scope: 1 Complaint# NV00070621			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 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 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	0878	On 04/23/2024 training was conducted with the Prestige Assisted Living of Henderson Health Services team to review the policy and procedure for the Following: Documentation, Incident Reports, Notifications, Medication Release and Disposal, Medication Services, Medication Order Flow process, Logging in of medications and SPA's (Service Plan Addendum). Please See Attached in-service sign in sheet. Attached is proof of medications are on site for Resident 4 & Resident 9. The administrator and/or its designee as well as the Health Services Team will ensure that the delivery of Medication Services is within NV NRS regulatory compliance, Prestige policy and procedure and industry standards. The administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	05/10/2024

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		A. BUILDING _____ B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ASSISTED LIVING AT HENDERSON	**1050 E LAKE MEAD PARKWAY, HENDERSON, NEVADA ,89015**

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	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. Inspector Comments: Based on observations, interviews, and record review the facility failed to ensure prescribed medications were available for 2 of 15 sampled residents (Resident #4 and Resident #9). Findings include: Resident #4 (R4) R4 was admitted to the facility on 06/24/2022 with a diagnosis of epilepsy. A physician's order dated 02/20/2024 documented Lactase Oral Tablet Chewable Give one capsule by mouth two times a day for Probiotic. A physician's order dated 02/19/2024 documented Melatonin oral 10 milligrams (mg) give one tablet every 24 hours as needed for insomnia. On 03/27/2024 in the morning while conducting a review of R4's medications both the Lactase Oral Tablet and Melatonin were not available. Resident #9 (R9) R9 was admitted to the facility on 09/26/2023 with a diagnosis of hypertension. A physician's order dated 11/03/2023 documented Meclizine 12.5 mg give one tablet by mouth as needed for dizziness. On 03/27/2024 in the morning while conducting a review of R9's medications the Meclizine 12.5 mg was			

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	not available. On 03/27/2024 in the morning the Resident Care Coordinator verified the following medications were not available: - Lactase Oral Tablet - Melatonin 10 milligrams - Meclizine 12.5 mg On 03/27/2024 at 1:04 PM the Resident Service Director indicated all prescribed medications for residents should have been available to be administered. Severity: 2 Scope: 1 Complaint# NV00070621			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (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. Inspector Comments: Based on interview and record review the facility failed to ensure the Medication Administration Record (MAR) Based on interview and record review the facility failed to ensure the Medication Administration Record (MAR) was accurately completed for 1 of 15	0895	On 04/23/2024 training was conducted with the Prestige Assisted Living of Henderson Health Services Staff to review the policy and procedure for the Following: Documentation, Incident Reports, Notifications, Medication Release and Disposal, Medication Services, Medication Order Flow process, Logging in of medications and SPA's (Service Plan Addendum). Moving forward, the health services team will verify medication orders for accuracy upon admission to match MAR and medications onsite. Please see the attached document for Resident #4 MAR and photo of missing medication The administrator and/or its designee as well as the Health Services Team will ensure that the delivery of Medication Services is within NV NRS regulatory compliance, Prestige policy and procedure and industry standards. The administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	04/30/2024

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	sampled residents (Resident #4), Findings include: Resident #4 (R4) R4 was admitted to the facility on 06/24/2022 with a diagnosis of epilepsy. On 03/27/2024 the following medications were observed in R4's medications bin but were not documented on the March 2024 MAR: - Banophen 25 milligrams (mg) as needed for itching. - Ondansetron 4 mg as needed for nausea. On 03/27/2024 in the morning the Resident Care Coordinator acknowledged both medications had not been documented on the MAR. Severity: 2 Scope: 1			
0991 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: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the Administrator failed to ensure the alarms on two doors in the Memory Care unit were operational. Findings include: On 03/27/24 at 9:10 AM, the door leading onto the patio of the memory care unit did not alarm or open after 15 seconds, as indicated by signage. On 03/27/24 at 9:10 AM, the Maintenance Director explained there was no power to the mag lock, resulting in no audible alarm. The Maintenance Director stated there was a work order to repair the door. A repair work order dated 03/21/24 was provided, which indicated the company would return and replace the delayed mag lock and make all wire connection as needed, no completion date specified. There was no plan provided to ensure residents would not	0991	On April 18th an estimate was obtained by Fastec Fire & Safety Company for the repair and scheduled maintenance of the Memory Care door. This work was completed on April 25th, 2024. The mag lock and function of the door is fully operational in accordance with Nevada State Fire Code. Please see attached invoice and photos of repaired doors. The administrator and/or its designee AND STAFF will ensure this door is functional at all times with daily checks. In the chance there is a malfunction of the door, community administration will be notified immediately, a staff member will be assigned to watch to door to ensure a resident does not attempt an elopement, a high priority work ordered will be generated on TELS and if the malfunction cannot be corrected, a phone call into the vendor will be placed. The administrator and/or its designee will monitor the function and security of the memory care unit and door. The administrator will be responsible to ensure compliance. Date of compliance 04/30/2024	04/30/2024

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	exit the through the door without alerting staff. On 03/27/24 in the morning, the rear exit door leading to the outside of the memory care facility was not locked nor alarmed. The door was blocked with a settee and an adjustable rail device. The door opened upon depression of the door handle. There were no staff monitoring the door to ensure residents or others would not walk out the rear exit. On 03/27/24 in the morning, the Maintenance Director acknowledged the door was not locked or alarmed, and provided a proposal for the repairs from the repair company. The proposal, signed by the Maintenance Director on 03/07/24, indicated the repair company was 4-plus weeks out on scheduling at the time of approval of the proposed work. Severity: 2 Scope: 3 Complaint #NV00070621			

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0994 SS= E	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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp and dangerous items were kept out of reach of residents on the memory care unit. Findings include: On 03/27/24 in the morning, an electric saw and an electric grill were observed in the unlocked whirlpool room on the memory care unit. On 03/27/24 at 10:40 AM, the Maintenance Director acknowledged the electric saw and the electric drill needed to be secured and removed them from the room. Severity: 2 Scope: 3 Complaint #70621	0994	**On 03/27/2024 the electric saw and electric grill were removed from the whirlpool area.** 04/04/24 specific training was provided to staff of Prestige Assisted Living of Henderson regarding resident safety and restricted products in Assisted Living and Memory Care living areas. This includes but is not limited to Knives, matches, candles, firearms, tools, toxic/harmful chemicals, personal hygiene products, lotions, nail care products or other products that could constitute dangers to the residents of PALoH. These items must be secured when not in use and/or returned to the POA or destroyed. Please see attached in-service sign in sheet and Expressions Environmental Safety policy. The administrator and/or its designee, along with PALoH staff will provide daily sweeps and security of all units to ensure compliance and resident safety. Additional review and enforcement of the Alzheimer's Care and Standards regulation will be provided to all vendors, visitors and family members either verbally or in writing. The administrator is responsible to ensure compliance. Date of compliance 04/30/2024	04/30/2024

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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 not accessible to residents in the memory care unit. Findings include: On 03/27/24 in the morning, two canisters of disinfecting wipes were observed in an upper cupboard of the memory care unit kitchen. On 03/27/24 at 9:19 AM, the Maintenance Director acknowledged the disinfecting wipes and agreed the wipes should not be accessible to residents. Severity: 2 Scope: 3	0999	On 04/04/24 specific training was provided to staff of Prestige Assisted Living of Henderson regarding resident safety and restricted products in Assisted Living and Memory Care living areas. This includes but is not limited to Knives, matches, candles, firearms, tools, toxic/harmful chemicals, personal hygiene products, lotions, nail care products or other products that could constitute dangers to the residents of PALoH. These items must be secured when not in use and/or returned to the POA or destroyed. Please see attached in-service sign in sheet and Expressions Environmental Safety policy. The administrator and/or its designee, along with PALoH staff will provide daily sweeps and security of all units to ensure compliance and resident safety. Additional review and enforcement of the Alzheimer's Care and Standards regulation will be provided to all vendors, visitors and family members either verbally or in writing. The administrator is responsible to ensure compliance. Date of compliance 04/30/2024	04/30/2024

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1035 SS= D	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of tier 2 training . Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 10 employees received two hours of initial dementia training within the first 40 hours of employment (Employee #2). Findings include: Employee #2 (E2) E2 started on 05/31/2023 as the Life Enrichment Director . E2's file lacked documented evidence of two additional hours of dementia training within the first 40 hours of employment for the requirement of 10 total hours of initial dementia training within the first three months of hire. On 03/27/2024 in the afternoon, the Acting Administrator acknowledged E2's file lacked documented evidence of an additional two hours of dementia training within three months of hire. Severity: 2 Scope: 1	1035	The administrator and/or its designee will ensure that all employees complete **2 hours of tier 2 dementia training in their first 40 hours** of employment and 10 hours of dementia training in their first 3 months of employment. Copies of tier 1 and tier 2 trainings will be kept in the employee's file. Please see the attached certification of completions for employee #2. The administrator and/or its designee will ensure that tier 1 & tier 2 trainings will be provided in accordance with NAC 449.196. Copies of these trainings will be kept in the employees file. The administrator will be responsible to ensure compliance. Date of compliance: 04/30/2024	04/30/2024

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1036 SS= D	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 10 employees received at least eight hours of dementia training within three months of hire (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 05/31/2023 as the Life Enrichment Director. E2's file lacked documented evidence of at least eight hours of dementia training within three months of hire. On 03/27/2024 in the afternoon, the Acting Administrator acknowledged E2's file lacked documented evidence of at least eight hours of dementia training within three months of hire. Severity: 2 Scope: 1	1036	The administrator and/or its designee will ensure that all employees complete 2 hours of dementia training in their first 40 hours of **employment and 8 hours of dementia training in their first 3 months of employment.** Copies of tier 1 and tier 2 trainings will be kept in the employee's file. Please see the attached 8 hours of certification for employee #2. The administrator and/or its designee will ensure that tier 1 & tier 2 trainings will be provided in accordance with NAC 449.196. Copies of these trainings will be kept in the employees file. The administrator will be responsible to ensure compliance. Date of compliance: 04/30/2024	04/30/2024
1037 SS= D	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease,	1037	The administrator and/or its designee will ensure that all employees complete 2 hours of dementia training in their first 40 hours of employment and 10 hours of dementia training in their first 3 months of employment. Copies of tier 1 and tier 2 trainings will be kept in the employee's file. **Additional training will include 3 hours of annual continuing education of those who have dementia, completed before their anniversary date of hire.** Please see the attached certification of	04/30/2024

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	successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the facility failed to ensure three hours of annual Alzheimer's training was completed by 1 of 10 employees (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 05/31/2023 as the Life Enrichment Director. E2's file lacked documented evidence of three hours of current annual Alzheimer's training. On 03/27/24 in the afternoon, the Acting Administrator acknowledged E2's file lacked documented evidence of current annual Alzheimer's training . Severity: 2 Scope: 1		completion for employee #2. The administrator and/or its designee will ensure that tier 1 & tier 2 trainings will be provided in accordance with NAC 449.196. This will be achieved by monthly and annual audits of training records. Copies of these trainings will be kept in the employee's file. The administrator will be responsible to ensure compliance. Date of compliance: 04/30/2024	
1540 SS= E	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any	1540	The administrator and/or its designee will ensure that all staff will receive within 30 days of hire and annually thereafter Cultural Competency Training. This training will include how to treat and care for residents who have a different cultural background. The training will be provided by a state	04/30/2024

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PRESTIGE ASSISTED LIVING AT HENDERSON	**1050 E LAKE MEAD PARKWAY, HENDERSON, NEVADA ,89015**

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	agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the Department or his or her designee pursuant to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 15 3. When a facility submits a course		approved third party vendor either in person, video, internet or other form of approved media. This community is contracted with Flex Ed for its CC training. Please see the attached certificates of training for Employees #2,4 &7. Employee #5 is no longer with the company. The administrator and/or its designee are responsible to ensure compliance. This will be achieved by monthly and annual audits of training records. Date of compliance: 04/30/2024.	

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		A. BUILDING _____ B. WING _____	**03/27/2024**

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	or program pursuant to subsection 1, the facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of			

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	the course or program to print and sign his or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec. 15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a			

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	person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4 of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by			

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	federal, state or local government agencies; or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not received or fails to include all of the information that the Director or his or her designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 10 employees received cultural competency training (Employee #2, #4, #5 and #7). Findings include: Employee #2 (E2) E2 was hired on 05/31/2023 as the Life Enrichment Director. E2's file lacked documented evidence of cultural competency training. Employee #4 (E4) E4 was hired on 02/14/2023 as a Medication Technician. E4's file lacked documented evidence of cultural competency training. Employee #5 (E5) E5 was hired on 08/13/2023 as a Medication Technician. E5's file lacked documented evidence of cultural competency training. Employee #7 (E7) E7 was hired on 03/17/2021 as a Personal Care Attendant. E7's file lacked documented evidence of cultural competency training. On 03/27/2024 in the afternoon, the Acting Administrator acknowledged E2, E4, E5 and E7 had not completed cultural competency training. Severity: 2 Scope: 2			
1830 SS= D	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as	1830	The administrator and/or its designee appointed as the Infection Control Officer will take 15 hours of Infection Control training provided by a third-party vendor or	04/30/2024

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	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 designees completed 15 hours of infection control training from a nationally recognized organization (Employee #11 and #12). Findings include: Employee #11 (E11) E11 was hired as the Resident Care Coordinator. E11's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. Employee #12 (E12) E12 was hired as the Resident Service Director. E12's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. On 03/27/24 in the afternoon, The Regional Support Nurse confirmed E11 was the primary infection control program designee and E12 was the secondary infection control designee. The regional Support Nurse acknowledged E11 and E12 files		the CDC. These programs meet the current, evidence-based standards for Infection Control and the safety needs of the residents, staff and visitors. This is the initial training for this community. Included are the training certificates for the Administrator, Executive Director and Resident Care Coordinator. Training certificates will be kept in the employees file. The administrator is responsible for compliance. Date of compliance 4/30/24	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization. Severity: 2 Scope: 1			