STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3382	A. BUILDING _____ B. WING _____	05/13/2026

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GOLDEN MEADOWS RESIDENTIAL	4119 MEADOWGLEN CIRCLE, LAS VEGAS, NEVADA ,89121

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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 05/13/26. The census at the time of the survey was eight. The sample size was five. The facility received a grade of C. There was one complaint investigated. Substantiated: 1. Complaint#13638 was substantiated. (See TAGs 050, 088, 515, 820, 840, 850, 930 and 950) The investigation of the complaint included: Observations of facility staffing, residents receiving care and a tour of the facility. Interviews were conducted with the resident of concern, residents, a hospice Director of Nursing, a hospice nurse, a hospice certified nursing assistant, the House Manager, and the Owner. Clinical Record Review of five records. Document Review included employee schedules and facility policy and procedures.			
Y 0050 SS= G	**NAC 449.194** **Responsibilities of administrator.** The administrator of a residential facility shall:	Y 0050	1) The Administrator and manager of the facility will immediately resume active oversight of all residents and staff care. 2) The administrator and manager will hold weekly staff meeting to hold residents care and staff concerns and wound care directives. For tag #0088 Administrator/ Manager will	06/19/2026

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	1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, interview, record review and document review, the Administrator of the facility failed to provide oversight and direction for staff and protective supervision to ensure a resident with wounds received needed services; (Resident #1) and that the facility was in compliance with NAC 449.156 to 449.2766, inclusive and chapter 449 of the NRS. Findings include: See TAG Y0088 for failure to ensure staffing schedules were available for review upon inspection. See TAG Y0515 for failure to ensure a care plan was updated and implemented with the services the resident required. See TAG Y0820 for admitting a resident with a wound that was not in the process of healing and failing to obtain a medical exemption to maintain the resident with wounds See TAG 0840 for the Bureau of Health Care Quality and Compliance determining a current review by a physician of the physical condition of a resident with wounds was necessary. See TAG 0850 for failing to ensure a resident received the personal care services they required including repositioning every 2 hours and consistent brief changing as directed by the resident's hospice.		create monthly staffing schedules at the start of each month and will be posted in the facility and will kept in a binder in the facility storage cabinet and will retain for at least a minimum for 6 months after the expiration date and maintaining and amending schedules and changes as they occur. For tag #0515 a person centered service plan was implemented and the Administrator/ Manager will ensure all residents care plans document who and when residents need repositioning every 2 hours. For tag #0820 a pre admission screening policy form will be implemented and all residents with open wounds will be evaluated for compliance, if they do not meet the criteria the resident will not be admitted to the facility. For tag #0840 the facility will request a physician reassessment anytime a resident experiences a significant change in condition of wounds or wound worsening. For tag #0850 a mandatory Personal Care & Repositioning log has been implemented for any residents with wounds. Staff must document each reposition every 2 hours and brief change. For tag #0930 all ADL assessments will be reviewed and updated within 24 hours of any change of condition and will reflect current status, repositioning, incontinent needs and directive care. For tag #0950 all necessary documents and visit for hospice notes and wound care notes will be in residents files and all files will be audited to make sure all files are current. 3)A tracking log will be implemented to document clinical communications from outside providers, MD manager follow up actions 4)Administrator and Manager is responsible for this compliance 5) 6/19/26	

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	See TAG 0930 for failing to ensure a resident's ADL (Activities of Daily Living) assessment included documentation of service provisions for a resident with wounds who needed repositioning every 2 hours. See TAG 0950 for failing to ensure a resident's Wound Care Specialist notes and Hospice records were retained and available to review for a resident who was receiving hospice and wound care services. Severity: 3 Scope: 1 Complaint#: 13638			

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Y 0088 SS= F	**NAC 449.199** 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6months after the schedule expires. Inspector Comments: Based on observation, interview and document review, the facility failed to maintain and make available a written monthly employee schedule as required. On 05/13/26 in the morning, the current employee schedule was not posted in the facility. On 05/13/26 in the morning, when requested by an inspector from the Nevada Health Authority, the Owner stated they were unable to locate the employee schedules for March, April, and May 2026. On 05/13/26 in the morning, the House Manager acknowledged that the March, April, and May 2026 employee schedules were not onsite and confirmed they should have been available. The inspector provided the facility until 5:00 PM on 05/16/26 to submit the requested schedules to the Nevada Health Authority. On 05/19/26 in the morning, the House Manager had submitted only the April 2026 employee schedule. The facility failed to submit the March 2026 and May 2026 employee schedules as directed. Severity: 2 Scope: 3 Complaint# 13638	Y 0088	1) All current and future monthly staffing schedules will be created at the start of each month, posted in the facility. 2& 3) A designated binder will be kept on premises for this purpose. The manager will be responsible for maintaining and amending schedules as changes occur. Effective, the current month's schedule is posted on the facility staff bulletin board in the kitchen/ staff area, visible to all staff and available to surveyors upon request at all times. The schedules will be retained in a binder for a minimum of 6 months after the schedule's expiration date. Schedules will be stored in the facility office filing cabinet. 4) Administrator and office manager is responsible to maintain compliance. 5) 6/19/26 6) see attachment for Feb, March, April, May 2026	06/19/2026
Y 0515		Y 0515	1) Resident #1 was discharged on 06/09/26	06/19/202

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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; (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		on the voluntary request of the family to relocate the resident closer to the Power of Attorney. see discharged form for Resident #1 2 &3) The facility has implemented prospective policies to ensure care plan compliance of all current and future residents. Effective immediately the House Manager or Administrator will ensure a residents care plan accurately documents residents who need repositioning every 2 hours and which residents require repositioning every 2 hours and/ or not admitting residents with wounds that the facility can not meet the needs of the resident. All caregivers will be trained on how to do repositioning every 2 hours with the supervision by the manager and Administrator. 4)Administrator is responsible for this compliance 5)06/19/26 6) see attached Person centered service plan	6

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	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 ensure an individualized care plan included documentation of service provisions for a resident with wounds who needed repositioning every 2 hours. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 09/23/25 with diagnoses including senile degeneration of the brain and polyneuropathy. A discharge summary from a skilled nursing facility dated 09/23/25 documented R1 had the following wounds: · a stage 1 left ischial tuberosity · a stage 2 at the coccyx 11/19/25 Wound Care Notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 12/05/25 Wound Care Notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 01/03/26 Hospice Visit Notes at 12:30 PM documented hospice reinforced to Caregiver repositioning, incontinence management and applying barrier cream after diaper change. 01/21/26 Wound Care Notes documented hospice provided caregiver education on offloading measures to prevent further deterioration and promote healing. 01/26/26 Hospice Visit Notes at 10:15 AM			

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	documented hospice reinforced with Caregivers the need to reposition R1 every 2 hours and to keep the area free from pressure. 01/28/26 Wound Care Notes documented hospice provided caregiver education on offloading measures to prevent further deterioration and promote healing. 02/03/26 Hospice Visit Notes at 8:00 AM documented hospice educated the Caregiver regarding maintaining R1 clean and dry to prevent further skin breakdown. 02/20/26 Hospice Visit Notes at 2:40 PM documented the Caregiver was educated and reinforced on repositioning resident every 2 hours and consistent heel offloading. 03/06/26 Hospice Visit Notes at 4:30 PM documented the caregiver was educated to reposition R1 every 2 hours and to offload heels consistently to prevent additional pressure injuries. 03/13/26 Hospice Visit Notes at 11:20 AM documented the Caregiver was educated to reposition R1 every 2 hours, maintain clean and dry skin, offload heels and pressure points. 03/20/26 Hospice Visit Notes at 9:30 AM documented that extensive education was given to the Caregiver regarding strict repositioning every 2 hours, importance of offloading of heels, moisture management and adherence to wound care regimen to prevent further deterioration. 03/23/26 Hospice Visit Note at 2:30 PM documented education was provided to the Caregiver with a reinforced strict repositioning schedule every 2 hours, proper offloading of pressure areas, and the importance of maintaining clean and dry skin. Caregiver was instructed to monitor R1's wounds for signs of infection. 03/30/26 Hospice Visit Note at 1:30 PM documented the Caregiver noted to be noncompliant with turning schedule.			

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	Education was provided and reinforced regarding the critical importance of repositioning every 2 hours to prevent further skin breakdown and promote wound healing. Caregiver verbalized understanding, but continued noncompliance remains a concern. 04/02/26 Hospice Visit Note at 3:00 PM documented Caregiver shows inconsistent repositioning. Education was provided and reinforced regarding the importance of turning and repositioning every 2 hours to prevent further skin breakdown. 04/07/26 Hospice Visit Notes at 9:30 AM documented education provided extensively to the Caregiver regarding strict repositioning every 2 hours, offloading pressure areas including heels, proper wound care techniques and prompt dressing changes if soiled. 04/15/26 Wound Care Notes documented the group home Caregiver was informed that was important to offload R1 from pressure points. 04/16/25 Hospice Visit Notes at 11:40 AM documented preventative measures were reinforced, including strict turning schedule, pressure offloading, and skin monitoring to prevent further breakdown. 04/28/26 Hospice Visit Notes at 12:00 PM documented education reinforced with the Caregiver regarding strict repositioning every 2 hours, offloading bilateral heels, maintaining clean skin on R1 at all times and promptly changing any soiled or dislodged dressings to prevent further skin breakdown. 05/01/26 Hospice Visit Notes at 1:45 PM documented extensive and strict Caregiver education reinforced regarding strict repositioning every 2 hours, offloading heels at all times, maintaining R1 as being clean and dry, and prompt incontinent care. 05/06/26 Wound Care Notes documented caregivers were educated to reposition R1 and keep R1's wound from getting worse. A			

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	new wound was noted on R1's right heel. The notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. On 05/13/26 in the morning, R1's individualized resident care plan dated 09/25/25 lacked documented evidence of R1 having wounds and the care that was to be provided for the wounds. The care plan lacked documented evidence of R1 needing repositioning every 2 hours as instructed by hospice. On 05/13/26 in the morning, the Owner reported being unaware whether R1 was admitted to the facility with wounds and reported thinking R1 had developed the wounds approximately 2 – 3 months ago. On 05/13/26 in the morning, the House Manager verbalized being unaware of when R1 developed wounds. The House Manager acknowledged R1's plan of care lacked documented evidence that R1 had wounds and what care was to be provided to R1. The House Manager acknowledged being informed by hospice to reposition R1 every 2 hours, but this was not included in R1's care plan. Severity: 2 Scope: 1 Complaint# 13638			
Y 0820 SS= D	**NAC 449.2734** **Residents having tracheostomy or open wound requiring treatment by a medical professional; residents having pressure or stasis ulcers.** 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a	Y 0820	1) Resident #1 was discharged on 06/09/26. 2/3) All future residents that have wounds will need to meet the criteria of the new regulations along with our pre admission wound policy form before admission. See attachment pre admission wound policy. A written admissions policy will be implemented requiring that prior to or at the time of admission, any resident with open wounds will be evaluated for compliance. If a wound does not meet criteria, admission will be declined. We will not any admit any individual with an	06/19/2026

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	residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or (c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician; (b) The condition must be cared for by a medical professional who is trained to provide care for and reassessment of that condition; and (c) Before a caregiver provides care to a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer, the caregiver must receive training related to the prevention and care of pressure sores from a medical professional who is trained to provide care for that condition. 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The records must include an explanation of		open wound requiring treatment by a medical professional, and will not permit any current resident to remain at the facility with such a wound. 4) The administrator and manager will be responsible for this compliance 5) 6/19/26 6) Please see attached pre admission wound screening policy form	

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	the cause of the pressure or stasis ulcer. Inspector Comments: Based on observation, interview and record review, the facility 1) admitted a resident with a wound that was not in the process of healing and 2) failed to obtain a medical exemption to maintain a resident with wounds (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 09/23/25 with diagnoses including senile degeneration of the brain and polyneuropathy. A discharge summary from a skilled nursing facility dated 09/23/25 documented R1 had the following wounds: * a stage 1 left ischial tuberosity * a stage 2 at the coccyx 11/19/25 Wound Care Notes documented R1 presented for wound care follow up of a pressure ulcer located at the sacrum that developed 2 months ago and worsened over time. The pressure ulcer of the sacral region was staged at stage 4. 12/05/25 Wound Care Notes documented R1 presented for wound care follow up of a sacral ulcer with skin graft application. Primary concern was monitoring the progress of R1's stage 4 sacral ulcer that was unstageable due to devitalized tissue. R1 now has a sacral ulcer that is stage 4 and receiving skin graft application for the first time. 01/03/26 Hospice Visit Notes at 12:30 PM documented R1 has a stage 4 pressure ulcer on R1's coccyx area that measures 7.4 x 6.2 x 4 centimeters (cm). 01/26/26 Hospice Visit Notes at 10:15 AM documented R1 had a new pressure injury on R1's right heel.			

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	02/11/26 Hospice Visit Notes at 11:30 AM documented R1's right heel presented with a stage 3 pressure injury with a foul odor coming from the wound. R1's physician was notified and an antibiotic was ordered for R1's suspected infection. 03/20/26 Hospice Visit Notes at 9:30 AM documented R1's skin assessment revealed overall decline and worsening of wound areas likely due to inconsistent repositioning and inadequate pressure offloading. Left lower leg presented with a stage 2 pressure injury with surrounding tissue now showing additional non-blanchable redness indicative of a new stage 1 involvement measuring 3 cm x 3.5 cm, reflecting further skin breakdown. Right heel measures 1 cm x .9 cm x .1 cm with a newly developed adjacent non-blanchable redness measuring 3.5 cm x 3.5 cm further indicating lack of consistent offloading. Sacral wound was found to be uncovered with surrounding erythema indicating poor adherence to turning schedule. Wound measures 3.4 cm x 1.7 cm x 3.2 cm, stage 4 with full thickness tissue loss, serous drainage and malodor present. 03/23/26 Hospice Visit Note at 2:30 PM documented heel boots were applied for pressure offloading. 04/02/26 Hospice Visit Note at 3:00 PM documented R1's stage 2 pressure ulcers to the right and left lower leg had no change in measurements and no improvement observed. R1's sacral wound was found with soiled dressing upon arrival. 04/15/26 Wound Care Notes documented R1 presented for wound care follow up of a stage 4 sacral ulcer with 7th skin graft application and right lower limb wound. 04/16/25 Hospice Visit Notes at 11:40 AM documented the sacral wound showed no signs of healing progression. Dressing was noted to be soiled with dislodged packing. Right lower limb wound shows increase in size, now measuring 4.1 cm x 3.7 cm x 0.3 cm.			

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	3382	A. BUILDING _____ B. WING _____	05/13/2026

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	05/01/26 Hospice Visit Notes at 1:45 PM documented existing wounds continue with no significant improvement. Sacral wound continues to be comanaged with wound care twice weekly. Bilateral lower extremity wounds continue to be managed by hospice. Stage 3 wound to right lower leg showed no improvement at this time. Noted worsening redness around the area and drainage. Left lower leg stage 2 wound with no healing and improvement. Surrounding back and buttocks area around the sacral wound exhibited redness and moisture associated irritation. 05/06/26 Wound Care Notes documented R1 presented for wound care follow up of a stage 4 sacral ulcer with 8th skin graft application and right lower limb wound. On 04/29/26 grafting was completed on the sacral wound where R1 remained in bed where R1 requires full assistance from R1's Caregivers. Caregivers were educated to reposition R1 and keep R1's wound from getting worse. A new wound was noted on R1's right heel. R1's file lacked an approved medical exemption from the Bureau for R1's wounds and to retain R1 at the facility. On 05/13/26 in the morning, the Owner acknowledged R1 had wounds and thought that R1 developed the wounds approximately 2 – 3 months ago and was currently receiving wound care in the facility from hospice. On 05/13/26 in the morning, the House Manager acknowledged R1 did not have an approved medical exemption from the Bureau on file. Severity: 2 Scope: 1 Complaint #13638			
Y 0840 SS= D	NAC 449.2738	Y 0840	1) Resident #1 was discharged on 6/9/26. 2)Going forward the facility will request a physician reassessment anytime a resident experiences a significant change in condition, new wounds or wound worsening.	06/19/2026

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	Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. 1. If, after conducting an inspection or investigation of a residential facility, the bureau determines that it is necessary to review the medical condition of a resident, the bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the bureau, provide to the bureau: (a) The assessments made by physicians concerning the physical and mental condition of the resident; and (b) Copies of prescriptions for medication or orders of physicians for services or equipment necessary to provide care for the resident. 2. If the Bureau or the resident's physician determines that the facility is prohibited from caring for the resident pursuant to NAC 449.271 to 449.2734, inclusive, or is unable to care for the resident in the proper manner, the administrator of the facility must be notified of that determination. Upon receipt of such a notification, the administrator shall, within a period prescribed by the Bureau, submit a plan to the Bureau for the safe and appropriate relocation of the resident pursuant to NRS 449A.100 to a place where the proper care will be provided. 3. If an inspection or investigation reveals that the conditions at a residential facility may immediately jeopardize the health and safety of a resident, the administrator of the facility shall, as soon as practicable, ensure that the resident is transferred to a facility which is capable of properly providing for his care.		4) Administrator and manager is responsible for this compliance 5) 6/19/26	

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	Inspector Comments: Based on observation, document review, record review and interview, the Bureau of Health Care Quality and Compliance (HCQC) determined a current review by a physician of the physical condition of 1 of 5 sampled residents with wounds was necessary. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 09/23/25 with diagnoses including senile degeneration of the brain and polyneuropathy. 10/27/25 Hospice Visit Notes at 9:30 AM documented R1 had a stage 2 pressure ulcer on R1's coccyx. 11/10/25 Hospice Visit Notes at 9:30 AM documented it took 3 Caregivers and the hospice Registered Nurse to turn R1 over. R1's pressure ulcer is stage 2 on R1's coccyx. 11/19/25 Wound Care Notes documented R1 presented for wound care follow up of a pressure ulcer located at the sacrum that developed 2 months ago and has worsened over time. The pressure ulcer of the sacral region was staged at stage 4. The notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 12/05/25 Wound Care Notes documented R1 presented for wound care follow up of a sacral ulcer with skin graft application. Primary concern is monitoring the progress of R1's stage 4 sacral ulcer that was unstageable due to devitalized tissue. R1 now has a sacral ulcer that is stage 4 and receiving skin graft application for the first time. The facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 01/03/26 Hospice Visit Notes at 12:30 PM documented R1 has a stage 4 pressure ulcer on R1's coccyx area that measures			

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	7.4 x 6.2 x 4 centimeters (cm). Reinforced to Caregiver repositioning, incontinence management and applying barrier cream after diaper change. 01/21/26 Wound Care Notes documented R1's wound dressing was changed and/or removed for R1's stage 4 pressure ulcer in the sacral region. Caregiver education on offloading measures to prevent further deterioration and promote healing. 01/26/26 Hospice Visit Notes at 10:15 AM documented the RN spoke to the group homeowner regarding repositioning, keeping patient clean and dry and keeping wounds free of pressure. R1 had a new pressure injury on R1's right heel. Reinforced with Caregivers the need to reposition R1 every 2 hours and to keep the area free from pressure. 01/28/26 Wound Care Notes documented R1's wound dressing was changed and/or removed for R1's stage 4 pressure ulcer in the sacral region. Caregiver education on offloading measures to prevent further deterioration and promote healing. 02/03/26 Hospice Visit Notes at 8:00 AM documented the wound in R1's coccyx was soiled and needed to be changed. RN changed the dressing and R1 tolerated well. Wound specialist started to visit twice per week for the wound on right heel. 02/11/26 Hospice Visit Notes at 11:30 AM documented R1's right heel presented with a stage 3 pressure injury with a foul odor coming from the wound. R1's physician was notified and an antibiotic was ordered for R1's suspected infection. Educated Caregiver regarding maintaining R1 clean and dry to prevent further skin breakdown. 02/20/26 Hospice Visit Notes at 2:40 PM documented incontinent care was provided. R1's sacral wound dressing was found to be soiled, dressing was removed, wound was cleansed. Caregiver was educated and reinforced on repositioning resident every 2 hours and consistent heel offloading.			

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	03/03/26 Hospice Visit Notes at 10:00 AM documented R1's sacral wound dressing was changed during visit due to soiling. 03/06/26 Hospice Visit Notes at 4:30 PM documented R1's sacral wound dressing was found to be soiled. Caregiver was educated to reposition R1 every 2 hours and to offload heels consistently to prevent additional pressure injuries. 03/13/26 Hospice Visit Notes at 11:20 AM documented R1's sacral wound had no dressing upon arrival. Caregiver was educated to reposition R1 every 2 hours, maintain clean and dry skin, offload heels and pressure points. 03/20/26 Hospice Visit Notes at 9:30 AM documented R1's skin assessment revealed overall decline and worsening of wound areas likely due to inconsistent repositioning and inadequate pressure offloading. Left lower leg presented with a stage 2 pressure injury with surrounding tissue now showing additional non-blanchable redness indicative of a new stage 1 involvement measuring 3 cm x 3.5 cm, reflecting further skin breakdown. Right heel measures 1 cm x .9 cm x .1 cm with a newly developed adjacent non-blanchable redness measuring 3.5 cm x 3.5 cm further indicating lack of consistent offloading. Sacral wound was found to be uncovered with surrounding erythema indicating poor adherence to turning schedule. Wound measures 3.4 cm x 1.7 cm x 3.2 cm, stage 4 with full thickness tissue loss, serous drainage and malodor present. Extensive education was given to the Caregiver regarding strict repositioning every 2 hours, importance of offloading of heels, moisture management and adherence to wound care regimen to prevent further deterioration. 03/23/26 Hospice Visit Note at 2:30 PM documented heel boots were applied for pressure offloading. Education was provided to the Caregiver with a reinforced strict repositioning schedule every 2 hours, proper offloading of pressure areas, and the importance of maintaining clean and dry skin. Caregiver was instructed to monitor			

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	R1's wounds for signs of infection. 03/30/26 Hospice Visit Note at 1:30 PM documented the Caregiver noted to be noncompliant with turning schedule. Overall wound status shows minimal to no improvement, likely impacted by inconsistent repositioning. Education was provided and reinforced regarding the critical importance of repositioning every 2 hours to prevent further skin breakdown and promote wound healing. Caregiver verbalized understanding, but continued noncompliance remains a concern. 04/02/26 Hospice Visit Note at 3:00 PM documented R1's stage 2 pressure ulcers to the right and left lower leg had no change in measurements and no improvement observed. R1's sacral wound was found with soiled dressing upon arrival. Caregiver shows inconsistent repositioning. Education was provided and reinforced regarding the importance of turning and repositioning every 2 hours to prevent further skin breakdown. 04/07/26 Hospice Visit Notes at 9:30 Am documented sacral wound dressing noted to be soiled upon assessment. Wounds were cleansed and redressed. Education provided extensively to the Caregiver regarding strict repositioning every 2 hours, offloading pressure areas including heels, proper wound care techniques and prompt dressing changes if soiled. 04/15/26 Wound Care Notes documented R1 presented for wound care follow up of a stage 4 sacral ulcer with 7th skin graft application and right lower limb wound. The notes documented the group home Caregiver was informed that was important to offload R1 from pressure points. 04/16/25 Hospice Visit Notes at 11:40 AM documented the sacral wound showed no signs of healing progression. Dressing was noted to be soiled with dislodged packing. Right lower limb wound shows increase in size, now measuring 4.1 cm x 3.7 cm x 0.3 cm. Preventative measures were reinforced, including strict turning schedule, pressure			

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	offloading, and skin monitoring to prevent further breakdown. 04/28/26 Hospice Visit Notes at 12:00 PM documented R1's wounds showed no significant improvement or further healing. Education reinforced with the Caregiver regarding strict repositioning every 2 hours, offloading bilateral heels, maintaining clean skin on R1 at all times and promptly changing any soiled or dislodged dressings to prevent further skin breakdown. 05/01/26 Hospice Visit Notes at 1:45 PM documented existing wounds continue with no significant improvement. Sacral wound continues to be comanaged with wound care twice weekly. Bilateral lower extremity wounds continue to be managed by hospice. Stage 3 wound to right lower leg showed no improvement at this time. Noted worsening redness around the area and drainage. Left lower leg stage 2 wound with no healing and improvement. Surrounding back and buttocks area around the sacral wound exhibited redness and moisture associated irritation. Observed R1 is mainly on R1's back, showing continued non-compliance on repositioning of R1. Extensive and strict Caregiver education reinforced regarding strict repositioning every 2 hours, offloading heels at all times, maintaining R1 as being clean and dry, and prompt incontinent care. 05/06/26 Wound Care Notes documented R1 presented for wound care follow up of a stage 4 sacral ulcer with 8th skin graft application and right lower limb wound. On 04/29/26 grafting was completed on the sacral wound where R1 remained in bed where R1 requires full assistance from R1's Caregivers. Caregivers were educated to reposition R1 and keep R1's wound from getting worse. A new wound was noted on R1's right heel. The notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. On 05/13/26 in the morning, the Owner was unaware whether R1 arrived at the facility with wounds and thought R1 had developed			

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	the wounds approximately 2 – 3 months ago. On 05/13/26 in the morning, the House Manager verbalized being unaware of when R1 developed wounds. The House Manager acknowledged R1's plan of care lacked documented evidence that R1 had wounds and that the facility was supposed to reposition R1 every 2 hours. On 05/13/26 in the afternoon, a Hospice Director of Nursing (DON) reported staff did not believe R1 was being turned and the hospice agency increased their visits to assist with R1's wound care. According to the DON, R1's wounds had been there since before 12/01/25 and the hospice company had reached out to the group home about their concerns with R1's lack of care on numerous occasions, as documented by progress notes. The DON verbalized the hospice company recommended to R1's family that R1 be relocated to another facility due to their concerns about R1 not being repositioned. On 05/14/26 in the morning, a hospice certified nursing assistant (CNA) reported upon arrival to the facility in the mornings, R1 was heavily soiled on 3 to 4 of the 5 days the CNA visited. According to the CNA, they had been servicing R1 for approximately 2 months and R1's briefs had been consistently wet or soiled on those visits. The CNA verbalized the facility had new Caregivers about every week and the CNA was concerned as R1's brief did not appear to be changed at night. The CNA reported observing the wound on R1's sacrum bleeding and smelling when arriving in the mornings. On 05/14/26 in the morning, a hospice registered nurse (RN) reported that since February of 2026, the RN observed R1 was always laying in the same position in bed and not being repositioned. According to the RN, the RN had repeatedly shown the group home owner photos of R1's wound and spoken to the group home owner about how important it was for the facility to reposition R1 every 2 hours. The RN			

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	reported that R1 was consistently soiled upon hospice's arrival and R1's wound dressing had to be changed when it became soiled. The RN verbalized that R1's wound on the area around the heel was now degrading again as R1 was not being repositioned regularly. Review of R1's file revealed R1 lacked an individualized care plan which documented R1 had wounds and required repositioning every 2 hours, lacked an ADL assessment which documented R1 had wounds and required repositioning every 2 hours and lacked an approved medical exemption from the Bureau for R1's wounds. Review of wound care and hospice notes lacked documented evidence R1 had a reassessment of R1's condition from 11/19/25-05/06/26, as R1's wounds were increasingly getting worse. A review of R1's current physical condition was deemed necessary during the survey on 05/13/26 due to documented worsening of R1's wounds, lack of facility staff compliance with repositioning R1 every 2 hours and changing R1's brief timely to avoid wetness and soiling contribution to worsening wounds. Additionally, a review was deemed necessary due to a lack of documented and needed services in the care plan and ADL's assessment to address R1's worsening wounds. Severity: 2 Scope: 1 Complaint# 13638			
Y 0850 SS= G	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	Y 0850	1) Resident #1 was discharged on 06/09/26. Please see discharged form on file. 2 &3) A mandatory Personal Care & Repositioning log has been implemented for any residents with wounds.Staff must document each reposition every 2 hours and brief change. The administrator and staff shall ensure all required documents and care plan should be available in their file. 4) Administrator and Manager and	06/19/2026

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	becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a 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		caregivers are responsible for this compliance 5)6/19/26	

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	resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on interview and record review, the facility failed to ensure a resident received the personal care services they required including repositioning every 2 hours and consistent brief changing, as directed by the resident's hospice. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 09/23/25 with diagnoses including senile degeneration of the brain and polyneuropathy.			

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	On 05/13/26 at 8:43 AM, R1's room was observed to have a sign posted on the wall that read turn every 2 hours. A discharge summary from a skilled nursing facility dated 09/23/25 documented R1 had the following wounds: · a stage 1 left ischial tuberosity · a stage 2 at the coccyx R1's individualized care plan created by the facility and dated 09/25/25 lacked documented evidence of R1 having a wound. R1's ADL assessment created by the facility and dated 09/25/25 lacked documented evidence of R1 having a wound. 10/27/25 Hospice Visit Notes at 9:30 AM documented R1 had a stage 2 pressure ulcer on R1's coccyx. 11/10/25 Hospice Visit Notes at 9:30 AM documented it took 3 Caregivers and the hospice Registered Nurse to turn R1 over. R1's pressure ulcer is stage 2 on R1's coccyx. Called for wound care to do an evaluation of R1. 11/17/25 Hospice Visit Notes at 5:00 PM documented the RN cleansed and cleaned R1's wound dressing with the help of 2 Caregivers. Wound care was documented as starting on 11/13/25. 11/19/25 Wound Care Notes documented R1 presented for wound care follow up of a pressure ulcer located at the sacrum that developed 2 months ago and has worsened over time. The pressure ulcer of the sacral region was staged at stage 4. The notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. R1's file lacked documented evidence the care plan was updated to include the requirement to reposition R1 every 2 hours. R1's file lacked documented evidence the ADL assessment was updated to include			

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	the requirement to reposition R1 every 2 hours. R1's file lacked documented evidence the facility requested physician reassessment of R1's worsening wound. 12/05/25 Wound Care Notes documented R1 presented for wound care follow up of a sacral ulcer with skin graft application. Primary concern is monitoring the progress of R1's stage 4 sacral ulcer that was unstageable due to devitalized tissue. R1 now has a sacral ulcer that is stage 4 and receiving skin graft application for the first time. The facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 01/03/26 Hospice Visit Notes at 12:30 PM documented R1 has a stage 4 pressure ulcer on R1's coccyx area that measures 7.4 x 6.2 x 4 centimeters (cm). Reinforced to Caregiver repositioning, incontinence management and applying barrier cream after diaper change. 01/21/26 Wound Care Notes documented R1's wound dressing was changed and/or removed for R1's stage 4 pressure ulcer in the sacral region. Caregiver education on offloading measures to prevent further deterioration and promote healing. 01/26/26 Hospice Visit Notes at 10:15 AM documented the RN spoke to the group homeowner regarding repositioning, keeping patient clean and dry and keeping wounds free of pressure. R1 had a new pressure injury on R1's right heel. Reinforced with Caregivers the need to reposition R1 every 2 hours and to keep the area free from pressure. R1's file lacked documented evidence the facility requested physician reassessment of the new pressure ulcer to R1's right heel. 01/28/26 Wound Care Notes documented R1's wound dressing was changed and/or removed for R1's stage 4 pressure ulcer in the sacral region. Caregiver education on offloading measures to prevent further deterioration and promote healing.			

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02/03/26 Hospice Visit Notes at 8:00 AM documented the wound in R1's coccyx was soiled and needed to be changed. RN changed the dressing and R1 tolerated well. Wound specialist started to visit twice per week for the wound on right heel.

02/11/26 Hospice Visit Notes at 11:30 AM documented R1's right heel presented with a stage 3 pressure injury with a foul odor coming from the wound. R1's physician was notified and an antibiotic was ordered for R1's suspected infection. Educated Caregiver regarding maintaining R1 clean and dry to prevent further skin breakdown.

R1's file lacked documented evidence the facility requested physician reassessment of R1's worsening wound and potential infection to R1's right heel.

02/20/26 Hospice Visit Notes at 2:40 PM documented incontinent care was provided. R1's sacral wound dressing was found to be soiled, dressing was removed, wound was cleansed. Caregiver was educated and reinforced on repositioning resident every 2 hours and consistent heel offloading.

03/03/26 Hospice Visit Notes at 10:00 AM documented R1's sacral wound dressing was changed during visit due to soiling.

03/06/26 Hospice Visit Notes at 4:30 PM documented R1's sacral wound dressing was found to be soiled. Caregiver was educated to reposition R1 every 2 hours and to offload heels consistently to prevent additional pressure injuries.

03/13/26 Hospice Visit Notes at 11:20 AM documented R1's sacral wound had no dressing upon arrival. Caregiver was educated to reposition R1 every 2 hours, maintain clean and dry skin, offload heels and pressure points.

03/20/26 Hospice Visit Notes at 9:30 AM documented R1's skin assessment revealed overall decline and worsening of wound areas likely due to inconsistent repositioning and inadequate pressure

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	offloading. Left lower leg presented with a stage 2 pressure injury with surrounding tissue now showing additional non-blanchable redness indicative of a new stage 1 involvement measuring 3 cm x 3.5 cm, reflecting further skin breakdown. Right heel measures 1 cm x .9 cm x .1 cm with a newly developed adjacent non-blanchable redness measuring 3.5 cm x 3.5 cm further indicating lack of consistent offloading. Sacral wound was found to be uncovered with surrounding erythema indicating poor adherence to turning schedule. Wound measures 3.4 cm x 1.7 cm x 3.2 cm, stage 4 with full thickness tissue loss, serous drainage and malodor present. Extensive education was given to the Caregiver regarding strict repositioning every 2 hours, importance of offloading of heels, moisture management and adherence to wound care regimen to prevent further deterioration. R1's file lacked documented evidence the facility requested physician reassessment of the new pressure ulcer on R1's left lower leg and worsening of R1's wound at the right heel. 03/23/26 Hospice Visit Note at 2:30 PM documented heel boots were applied for pressure offloading. Education was provided to the Caregiver with a reinforced strict repositioning schedule every 2 hours, proper offloading of pressure areas, and the importance of maintaining clean and dry skin. Caregiver was instructed to monitor R1's wounds for signs of infection. 03/30/26 Hospice Visit Note at 1:30 PM documented the Caregiver noted to be noncompliant with turning schedule. Overall wound status shows minimal to no improvement, likely impacted by inconsistent repositioning. Education was provided and reinforced regarding the critical importance of repositioning every 2 hours to prevent further skin breakdown and promote wound healing. Caregiver verbalized understanding, but continued noncompliance remains a concern. 04/02/26 Hospice Visit Note at 3:00 PM documented R1's stage 2 pressure ulcers to			

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	the right and left lower leg had no change in measurements and no improvement observed. R1's sacral wound was found with soiled dressing upon arrival. Caregiver shows inconsistent repositioning. Education was provided and reinforced regarding the importance of turning and repositioning every 2 hours to prevent further skin breakdown. 04/07/26 Hospice Visit Notes at 9:30 Am documented sacral wound dressing noted to be soiled upon assessment. Wounds were cleansed and redressed. Education provided extensively to the Caregiver regarding strict repositioning every 2 hours, offloading pressure areas including heels, proper wound care techniques and prompt dressing changes if soiled. 04/15/26 Wound Care Notes documented R1 presented for wound care follow up of a stage 4 sacral ulcer with 7th skin graft application and right lower limb wound. The notes documented the group home Caregiver was informed that was important to offload R1 from pressure points. 04/16/25 Hospice Visit Notes at 11:40 AM documented the sacral wound showed no signs of healing progression. Dressing was noted to be soiled with dislodged packing. Right lower limb wound shows increase in size, now measuring 4.1 cm x 3.7 cm x 0.3 cm. Preventative measures were reinforced, including strict turning schedule, pressure offloading, and skin monitoring to prevent further breakdown. 04/28/26 Hospice Visit Notes at 12:00 PM documented R1's wounds showed no significant improvement or further healing. Education reinforced with the Caregiver regarding strict repositioning every 2 hours, offloading bilateral heels, maintaining clean skin on R1 at all times and promptly changing any soiled or dislodged dressings to prevent further skin breakdown. 05/01/26 Hospice Visit Notes at 1:45 PM documented existing wounds continue with no significant improvement. Sacral wound continues to be comanaged with wound			

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	care twice weekly. Bilateral lower extremity wounds continue to be managed by hospice. Stage 3 wound to right lower leg showed no improvement at this time. Noted worsening redness around the area and drainage. Left lower leg stage 2 wound with no healing and improvement. Surrounding back and buttocks area around the sacral wound exhibited redness and moisture associated irritation. Observed R1 is mainly on R1's back, showing continued non-compliance on repositioning of R1. Extensive and strict Caregiver education reinforced regarding strict repositioning every 2 hours, offloading heels at all times, maintaining R1 as being clean and dry, and prompt incontinent care. R1's file lacked documented evidence the facility requested physician reassessment of R1's worsening wounds. 05/06/26 Wound Care Notes documented R1 presented for wound care follow up of a stage 4 sacral ulcer with 8th skin graft application and right lower limb wound. On 04/29/26 grafting was completed on the sacral wound where R1 remained in bed where R1 requires full assistance from R1's Caregivers. Caregivers were educated to reposition R1 and keep R1's wound from getting worse. A new wound was noted on R1's right heel. The notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. R1's file lacked documented evidence the facility requested reassessment of the new wound at R1's right heel. On 05/13/26 in the morning, R1's file lacked documented evidence R1 had been repositioned every 2 hours as instructed by hospice from 11/19/25, when the facility was initially informed of the importance of repositioning R1 until the last wound care note reviewed by the surveyor on 05/06/26. On 05/13/26 in the morning, the Owner reported being unaware whether R1 arrived at the facility with wounds and thought R1 had developed the wounds approximately 2			

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	– 3 months ago. On 05/13/26 in the morning, the House Manager verbalized being unaware of when R1 developed wounds. The House Manager acknowledged R1's plan of care and ADL assessments lacked documented evidence that R1 had wounds and confirmed that neither the care plan nor the ADL assessment documented that the facility was to reposition R1 every 2 hours. The House Manager acknowledged being informed by hospice and wound care staff the facility needed to reposition R1 every 2 hours for the prevention of the wounds, and to provide regular brief changes when R1 was soiled or wet. The House Manager acknowledged the facility failed to document the 2-hour repositioning of R1 by staff. On 05/13/26 in the afternoon, a Hospice Director of Nursing (DON) reported staff did not believe R1 was being turned and the hospice agency increased their visits to assist with R1's wound care. According to the DON, R1's wounds had been there since before 12/01/25 and the hospice company had reached out to the group home about their concerns with R1's lack of care. The DON verbalized the hospice company recommended to R1's family that R1 be relocated to another facility due to their concerns about R1 not being repositioned. On 05/14/26 in the morning, a hospice certified nursing assistant (CNA) reported upon arrival to the facility for R1 in the mornings, R1 was heavily soiled on 3-4 of the 5 days the CNA visited. According to the CNA, they were providing incontinence care to R1 for approximately 2 months and R1's briefs had been consistently wet on 3-4 of the 5 days visited. The CNA verbalized the facility had new Caregivers every week and the CNA was concerned as R1 did not appear to be getting brief changes at night. The CNA reported observing the wound on R1's sacrum bleeding and smelling when arriving in the mornings. On 05/14/26 in the morning, a hospice			

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	registered nurse (RN) reported that since February of 2026, the RN had observed that R1 was always laying in the same position and not being repositioned. According to the RN, the RN had repeatedly shown the group home owner photos of R1's wound and spoken to the group home owner about how important it was for the facility to reposition R1 every 2 hours. The RN reported that R1 was consistently soiled upon hospice's arrival and R1's wound dressing was not being changed when it became soiled. The RN verbalized that R1's wound on the area around the heel was now degrading again as R1 was not being repositioned regularly. Admission Policy (no date) documented basic services include continuous care and supervision, observation of changes to physical, emotional, mental and social health. Severity: 3 Scope: 1 Complaint# 13638			
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	Y 0930	1) Resident #1 was discharged on 6/9/26. 2 &3) All future resident's assessments will be immediately updated to reflect current status, repositioning, incontinent needs, and follow care directives from hospice.Going forward ADL assessments will be reviewed and updated within 24 hours of any change of resident condition. Staff will be educated on the requirement to update ADL assessments when care needs change. 4) Administrator is responsible for compliance 5) 6/19/26	06/19/2026

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	resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (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			

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	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 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.			

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	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 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 interview and record review, the facility failed to ensure the ADL (Activities of Daily Living) assessment included documentation of service provisions for a resident with wounds who needed repositioning every 2 hours. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 09/23/25 with diagnoses including senile degeneration of the brain and polyneuropathy. A discharge summary from a skilled nursing			

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	facility dated 09/23/25 documented R1 had the following wounds: * a stage 1 left ischial tuberosity * a stage 2 at the coccyx 11/19/25 Wound Care Notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 12/05/25 Wound Care Notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. 01/03/26 Hospice Visit Notes at 12:30 PM documented hospice reinforced to Caregiver repositioning, incontinence management and applying barrier cream after diaper change. 01/21/26 Wound Care Notes documented hospice provided caregiver education on offloading measures to prevent further deterioration and promote healing. 01/26/26 Hospice Visit Notes at 10:15 AM documented hospice reinforced with Caregivers the need to reposition R1 every 2 hours and to keep the area free from pressure. 01/28/26 Wound Care Notes documented hospice provided caregiver education on offloading measures to prevent further deterioration and promote healing. 02/03/26 Hospice Visit Notes at 8:00 AM documented hospice educated the Caregiver regarding maintaining R1 clean and dry to prevent further skin breakdown. 02/20/26 Hospice Visit Notes at 2:40 PM documented the Caregiver was educated and reinforced on repositioning resident every 2 hours and consistent heel offloading. 03/06/26 Hospice Visit Notes at 4:30 PM documented the caregiver was educated to reposition R1 every 2 hours and to offload heels consistently to prevent additional			

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	pressure injuries. 03/13/26 Hospice Visit Notes at 11:20 AM documented the Caregiver was educated to reposition R1 every 2 hours, maintain clean and dry skin, offload heels and pressure points. 03/20/26 Hospice Visit Notes at 9:30 AM documented that extensive education was given to the Caregiver regarding strict repositioning every 2 hours, importance of offloading of heels, moisture management and adherence to wound care regimen to prevent further deterioration. 03/23/26 Hospice Visit Note at 2:30 PM documented education was provided to the Caregiver with a reinforced strict repositioning schedule every 2 hours, proper offloading of pressure areas, and the importance of maintaining clean and dry skin. Caregiver was instructed to monitor R1's wounds for signs of infection. 03/30/26 Hospice Visit Note at 1:30 PM documented the Caregiver noted to be noncompliant with turning schedule. Education was provided and reinforced regarding the critical importance of repositioning every 2 hours to prevent further skin breakdown and promote wound healing. Caregiver verbalized understanding, but continued noncompliance remains a concern. 04/02/26 Hospice Visit Note at 3:00 PM documented Caregiver shows inconsistent repositioning. Education was provided and reinforced regarding the importance of turning and repositioning every 2 hours to prevent further skin breakdown. 04/07/26 Hospice Visit Notes at 9:30 AM documented education provided extensively to the Caregiver regarding strict repositioning every 2 hours, offloading pressure areas including heels, proper wound care techniques and prompt dressing changes if soiled. 04/15/26 Wound Care Notes documented the group home Caregiver was informed			

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	that was important to offload R1 from pressure points. 04/16/25 Hospice Visit Notes at 11:40 AM documented preventative measures were reinforced, including strict turning schedule, pressure offloading, and skin monitoring to prevent further breakdown. 04/28/26 Hospice Visit Notes at 12:00 PM documented education reinforced with the Caregiver regarding strict repositioning every 2 hours, offloading bilateral heels, maintaining clean skin on R1 at all times and promptly changing any soiled or dislodged dressings to prevent further skin breakdown. 05/01/26 Hospice Visit Notes at 1:45 PM documented extensive and strict Caregiver education reinforced regarding strict repositioning every 2 hours, offloading heels at all times, maintaining R1 as being clean and dry, and prompt incontinent care. 05/06/26 Wound Care Notes documented caregivers were educated to reposition R1 and keep R1's wound from getting worse. A new wound was noted on R1's right heel. The notes documented the facility was to turn/reposition R1 every 2 hours and avoid direct pressure to the wound site. On 05/13/26 in the morning, R1's ADL assessment dated 09/25/25 lacked documented evidence of R1 having wounds and the care that was to be provided for the wounds. The ADL assessment lacked documented evidence of R1 needing repositioning every 2 hours as instructed by hospice. On 05/13/26 in the morning, the Owner reported being unaware whether R1 was admitted to the facility with wounds and reported thinking R1 had developed the wounds approximately 2 – 3 months ago. On 05/13/26 in the morning, the House Manager verbalized being unaware of when R1 developed wounds. The House Manager acknowledged R1's ADL assessment lacked documented evidence R1 had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3382	A. BUILDING _____ B. WING _____	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	wounds and what care was to be provided to R1. The House Manager acknowledged being informed by hospice to reposition R1 and that the ADL assessment lacked documented evidence that the facility was to reposition R1 every 2 hours. Severity: 2 Scope: 1 Complaint# 13638			
Y 0950 SS= D	NAC 449.275 **Residential facility that provides hospice care: Responsibilities of staff; retention of resident with special medical needs.** 1. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to NAC 449.0186 for that resident. 2. The members of the staff of the facility shall: (a) Maintain at the facility a written record of the care and services provided to a resident who receives hospice care; and (b) Report any deviation from the established plan of care to the resident's physician within 24 hours after the deviation occurs. Inspector Comments: Based on record review and interview, the facility failed to ensure Wound Care Specialist notes and Hospice records were retained and available to review for a resident who was	Y 0950	1) Resident was discharged on 6/9/26. 2 & 3) All necessary documents and visit for hospice notes and wound care notes will be in residents file. Going forward facility will maintain a dedicated section in each hospice resident file for all hospice wound care documentation.House manager will audit hospice resident files to verify records are current. 4) Administrator is responsible 5) 6/19/26	06/19/2026

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	receiving hospice and wound care services. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 09/23/25 with diagnoses including senile degeneration of the brain and polyneuropathy. R1 was admitted to Hospice care on 10/23/25. R1 began receiving wound care on 11/13/25. On 05/13/26 in the morning, R1's record was reviewed and lacked documented evidence of Wound Care Specialist notes and Hospice records related to the wound care of R1. On 05/13/26 in the morning, the House Manager confirmed R1 was receiving both specialized Wound Care and Hospice care from an outside agency and acknowledged there were no records onsite related to the ongoing wound care for R1. Severity: 2 Scope: 1 Complaint #NV12638			