Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	339	A. BUILDING _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME CARE FACILITY	4920 RONAN DRIVE, LAS VEGAS, NEVADA ,89110

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

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed at your facility on 10/13/26. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category I residents. The census at the time of survey was Six. Six resident files and three employee files were reviewed. The facility received a grade of A.			
Y 0890 SS= E	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.** 1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered;	Y 0890	**Plan of Correction — Y0890 / NAC 449.2744** **1. Corrective action for Residents #1 and #2** By 10/21/2026, the administrator and staff will reconcile both residents' MARs with current signed prescriber orders and pharmacy labels, specifically addressing: • **Resident #1:** Correct the losartan entry from 25 mg to 50 mg by mouth daily, consistent with the cited order, after confirming the current order. • **Resident #2:** Mark the atorvastatin 20 mg entry discontinued according to the prescriber's order and verify the active atorvastatin 40 mg nightly entry. • **Resident #2:** Add the omitted metformin 500 mg by mouth twice daily with morning and evening meals after confirming the current	10/21/2026

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	(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; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication. Inspector Comments: Based on record review and interview the facility failed to ensure the Medication Administration Record (MAR) included accurate documentation for 2 of 6 residents (Resident #1 and #2). Findings include: Resident #1 (R1)		order. The review will investigate what medications and doses were actually administered during the affected period, including the duplicate atorvastatin signatures and missing metformin documentation. Any possible medication errors or omissions will be referred promptly to the prescriber for evaluation and instructions. Findings, notifications, and follow-up will be documented. Original records will be preserved. Corrections and verified late entries will show the actual entry date, author, and explanation. Staff will not backdate entries or document administration that cannot be verified. **2. Identification of other affected residents** By 10/21/2026, the administrator and staff will audit all residents' current MARs against signed prescriber orders and pharmacy labels. The audit will identify incorrect strengths, omitted medications, duplicate entries, and discontinued medications remaining active. Discrepancies will be resolved and documented. **3. Measures to prevent recurrence** By 10/21/2026, all staff assisting with medications will receive documented training on accurate transcription, processing new and discontinued orders, and signing only for medications actually administered. A second trained staff member will verify each new or changed MAR entry against the signed order before use. Before each monthly MAR is placed into service, the administrator/designee will reconcile it against current signed orders rather than relying solely on the previous month's MAR. Questions or discrepancies will be resolved with the prescriber or pharmacist before the affected medication is administered. Training attendance and competency verification will be retained.	

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	R1 was admitted to the facility on 07/15/12 with diagnoses including schizophrenia and hypertension. On 10/13/26 in the morning, R1's October 2026 MAR and physician's orders were reviewed, and R1's medication containers were observed. R1's file contained a physician's order dated 10/07/26 for losartan 50 milligram tablet, take one tablet by mouth every day. R1's October 2026 MAR documented losartan 25 milligram tablet, take one tablet by mouth every day. R1's medication container contained a medication labeled losartan 50 milligram tablet, take one tablet by mouth every day. Resident #2 (R2) R2 was admitted to the facility on 06/10/24 with diagnoses including schizophrenia and diabetes. On 10/13/26 in the morning, R2's October 2026 MAR and physician's orders were reviewed, and R2's medication containers were observed. R2's file contained a physician's order dated 06/03/24 for atorvastatin 20 milligram tablet, take one tablet by mouth every night at bedtime and a physician's order dated 09/03/26 to discontinue the atorvastatin 20 milligram tablet and a physician's order dated 09/03/26 to start atorvastatin 40 milligram tablet, take one tablet by mouth every night at bedtime.		**4. Monitoring for continued compliance** The administrator/designee will audit all resident MARs daily for 30 days, weekly for eight weeks, and monthly for three additional months. Audits will check order accuracy, medication omissions, duplicate or discontinued entries, and administration signatures. The administrator will document findings, corrective actions, and follow-up. Any recurrence will result in staff retraining and renewed daily monitoring until 30 consecutive days of compliance are achieved. A few form has been created to ensure this medication error does not occur again.	

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	R2's October 2026 MAR documented atorvastatin 20 milligram tablet, take one tablet by mouth every night at bedtime and in a separate entry take atorvastatin 40 milligram tablet, take one tablet by mouth every night at bedtime. Both entries of the atorvastatin documented on October 2026 MAR were initialed as administered from 10/01/26 through 10/12/26. R2's medication container contained a medication labeled atorvastatin 40 milligram tablet, take one tablet by mouth every night at bedtime. R2's file contained a physician's order dated 06/19/24 for metformin 500 milligram tablet, take one tablet by mouth twice daily with morning and evening meals. R2's October 2026 MAR did not document metformin 500 milligram tablet, take one tablet by mouth twice daily with morning and evening meals. R2's medication container contained a medication labeled metformin 500 milligram tablet, take one tablet by mouth twice daily with morning and evening meals. On 10/13/26 in the morning, the Administrator acknowledged R2's October 2026 MAR was inaccurate and did not document the correct milligrams of atorvastatin noted in R2's physician's order dated 09/03/26 and verbalized R2 received the correct dosage noted on R2's medication container and physician's order. The Administrator acknowledged the Caregiver should not have initialed the atorvastatin 20 milligram tablet was administered when it was not available and discontinued. On 10/13/26 in the morning, the Administrator acknowledged R2's October 2026 MAR did not document metformin 500			

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	milligram tablet, take one tablet by mouth twice daily with morning and evening meals and verbalized it was not transcribed from R2's September 2026 MAR. On 10/13/26 in the morning, the Administrator acknowledged R1's October 2026 MAR was inaccurate and did not document the correct milligrams of losartan noted in R1's physician order dated 10/07/26 and verbalized R1 received the correct dosage noted on R2's medication container and physician's order. Severity: 2 Scope: 2			