STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7766	A. BUILDING _____ B. WING _____	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNLEY ESTATES	1130 CHISHOLM TRAIL, FERNLEY, NEVADA ,89408

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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 03/30/2026. The census at the time of the survey was 65. The sample size was eight. There were three complaints investigated. Complaint #12854 was substantiated. (See Tag Y0878) Complaint #12269 could not be substantiated. No regulatory deficiencies could be identified. Complaint #12382 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaints included: Observation of grooming and physical appearance of residents, residents in rooms, residents in common areas, staff providing care and supervision to residents, a meal observation, and a tour of the facility. Interviews were conducted with residents, a Resident Assistant, a Medication Aide, the Wellness Director and the Administrator. Clinical Record Review of eight records, which included the residents of concern. Document Review included incident reports and the facility's policies and procedures.			
Y 0878 SS= D	NAC 449.2742	Y 0878	On 12/22/2025, the identified team member was immediately removed from medication administration duties and prohibited from	01/05/2026

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	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 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,		further access to the medication cart pending review and retraining. On 01/05/2026, all Medication Technicians completed re-training regarding proper medication administration procedures, documentation requirements, and required communication processes related to medication pass responsibilities. Effective immediately, only one authorized Medication Technician will be assigned to each medication cart during a medication pass. If responsibility for a medication cart must be transferred to another authorized team member, a face-to-face handoff communication and complete narcotic count will be conducted and documented prior to the transfer of the cart. The community will complete daily reviews of QuickMAR medication administration records to ensure medications are administered and documented as prescribed by the physician. Monthly medication cart audits will also be completed to monitor medication administration practices, cart security, narcotic accountability, and documentation compliance. The Wellness Director and Designated Manager will provide ongoing daily oversight of medication administration operations and will review all audit findings monthly to ensure continued compliance.	

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	the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and interview, the facility failed to ensure medications were administered as prescribed for 1 of 8 sampled residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 12/02/2024, with diagnoses including vascular dementia and Alzheimer's disease. The resident was discharged from the facility on 01/23/2026. A charting note dated 12/22/2025 documented Resident #4 was given two doses of all scheduled 8:00 AM medications. The designated manager contacted the resident's hospice nurse for clarification on next steps. The hospice nurse stated the hospice nurse was not too concerned, would contact the physician and send over any recommendations or orders for the resident. Resident #4's December 2025 Medication Administration Record (MAR) documented the following medications were scheduled to be administered at 8:00 AM: -Ayr Saline nasal gel, apply topically around nostrils and under nose once every morning. -Fair Life Core Power, take 26 grams of protein by mouth every morning due to low protein levels. -Famotidine 20 milligram (mg) tablet, take one tablet by mouth every day. -Fluticasone Propionate 50 microgram (mcg) spray, inhale 1-2 sprays in each nostril daily to prevent allergies. -Losartan Potassium 25 mg tablet, take one tablet by mouth every day.			

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	-Methylated Multivitamin, take one tablet by mouth every morning. -Oxybutynin 5 mg tablet, take one tablet by mouth every day for urine frequency. -Potassium Chloride extended release 20 milliequivalent (meq) tablet, take two tablets by mouth in the morning. -Stimulant Laxative plus tablet, take one tablet by mouth daily – hold for loose stool. -Thera Tears 0.25% eye drops, instill one drop in both eyes twice daily for dry eyes. -Torsemide 20 mg tablet, give two tablets by mouth every morning. On 03/30/2026 at 3:31 PM, the Wellness Director (WD) verbalized any team member who was certified as a Medication Technician (Med Tech) could administer medications to residents. Medications were to be administered within one hour before and after the scheduled time on the MAR. Medication administration errors occurred when a medication was given incorrectly and included not having the mediation onsite, administering the wrong dose and administering a medication twice when it was not supposed to be. The WD confirmed the WD was familiar with Resident #4 and recalled the resident received two doses of all prescribed medications scheduled for 8:00 AM on 12/22/2025. The WD explained the facility was short a Med Tech on the morning of 12/22/2025. A Med Tech from the assisted living side of the facility went to the memory care unit to assist with medication administration until another staff member arrived. When the additional staff arrived, the Med Tech and additional staff member did not communicate regarding which medications had already been administered, and the Med Tech's documentation had not updated in the facility's electronic MAR. As soon as the WD was informed of the duplicate administration the facility notified the resident's hospice nurse, physician, and the resident's family member. The WD denied Resident #4 experienced any negative outcomes/side effects related to the error. The facility policy titled "Medication System			

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	Summary," dated 03/2018, documented the facility would establish and maintain a safe, effective 24-hour medication delivery system for team members to administer, provide assistance for administration of, or allow resident self-administration of prescription and non-prescription (over-the-counter) medication/treatment as allowed by state and pharmacy regulations. General requirements included being timely to provide medication administration/assistance according to physician orders. Severity: 2 Scope: 1 CPT 12854			