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LEGACY HOUSE OF CENTENNIAL HILLS	6310 N. DURANGO DRIVE, LAS VEGAS, NEVADA ,89149

(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
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: The Statement of Deficiencies was generated as a result of an annual state licensure survey conducted in your facility on 07/22/26. The census was 135. Twenty five resident records and 19 employee records were reviewed. The facility received a grade of C.			
Y 0074 SS= D	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually receive training to recognize and prevent theabuse of older persons before the license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive	Y 0074	Employee #9 completed the required annual Elder Abusetraining on July 23, 2026, correcting the identified deficiency. To prevent recurrence, the community has revised itsprocess for monitoring and completing annual Elder Abuse training. EffectiveAugust 10, 2026, community employees will be assigned the required annual ElderAbuse training sixty (60) days prior to their renewal date, based on their hiredate, to ensure adequate time for completion before the training expires.Employees with training due within the next sixty (60) days will receivenotification of the upcoming requirement, and department leaders will receivebi-weekly compliance reports identifying employees with training that is due. The Administrative Assistant will maintain the trainingcompliance tracker and tickler system, monitor upcoming renewal dates, notifyemployees of pending training requirements, and distribute the bi-weeklycompliance reports to department leaders. The training compliance tracker willbe reviewed during weekly leadership meetings to verify compliance, addressoutstanding training requirements, and ensure timely completion. Departmentleaders will be responsible for ensuring employees complete required	07/23/2026

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	thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse of older persons before the facility, agency or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care, facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter. 6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, 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, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving		trainingby the assigned due date. The Executive Director will be responsible for oversightof these tasks. To verify compliance with this process, the community completed an audit ofcurrent employees whose annual Elder Abuse training was due between January2026 and August 2026 to confirm that all required training has been completedand appropriately documented. Those identified needing to complete the annualElder Abuse training will have it completed by August 21, 2026.	

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	thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section. 8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection. 9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled employees completed annual elder abuse training (Employee #9). Findings include: Employee #9 (E9) was hired on 01/24/25, as a Caregiver. E9 completed elder abuse			

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	on 01/27/25. E9's file lacked documented evidence of annual elder abuse training. On 07/22/26 in the afternoon, the Administrator acknowledged the missing training and was unable to provide the documentation. Severity: 2 Scope: 1			
Y 0106 SS= D	**NAC 449.0113 and R089-24** 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation in accordance with the requirements of section 2 of R089-24; **Reference - R089-24 Sec. 2**. 1. A person who is required by this chapter to be certified in first aid, cardiopulmonary resuscitation or first aid and cardiopulmonary resuscitation may complete any training, course or program to become certified or to renew certification, as applicable, through: (a) In-person instruction only; (b) A combination of in-person instruction and virtual or electronic instruction, if interactive, hands-on skills training or skills verification is provided in person; or (c) Virtual or electronic instruction only, if interactive, hands-on skills training or skills verification is not prerecorded. 2. If a certificate is earned in accordance with the requirements of subsection 1, the Division shall accept a certificate issued by the American Red Cross, the American Heart Association, the Health and Safety Institute or another similar nationally recognized organization as proof of	Y 0106	To prevent recurrence, the community has revised its CPRtraining compliance process. Effective 8/10/2026, new hire CPR certificationswill only be accepted from approved providers, to ensure verification that thecertification includes the required hands-on skills component. New employeeswho do not possess a qualifying hands-on CPR certification at the time of hirewill be required to complete a hands-on CPR course, within thirty (30) days oftheir hire date. The community provides the opportunity for staff to attend anin-person, hands-on CPR training on a bi-weekly basis to ensure timely accessto training. The Administrative Assistant will maintain the CPR trainingcompliance tracker and tickler system, monitor upcoming certification renewaldates, enroll employees in CPR training as needed for initialcertification or renewal, notify employees of upcoming training requirements,and distribute bi-weekly compliance reports to department leaders. The trainingcompliance tracker will be reviewed during weekly leadership meetings to verifycompliance, address outstanding training requirements, and ensure timelycompletion. Department leaders will be responsible for ensuring employeescomplete required CPR training by the assigned due date. The	07/30/2026

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	certification or renewal of certification. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled employees received initial cardiopulmonary resuscitation (CPR) and first aid training in person (Employee #5). Findings include: Employee #5 (E5) was hired on 02/19/26, as a Caregiver. E5 completed first aid and CPR online on 12/05/24. E5's file lacked documented evidence first aid and CPR training was completed in person. On 07/22/26 in the afternoon, the Business Office Manager was unable to provide in person training for first aid and CPR for E5. Severity: 2 Scope: 1		Executive Directorwill be responsible for oversight of these tasks. To identify and correct other areas that may be affected by thesame deficient practice, the community completed an audit of current employeepersonnel files to verify that each employee has documentation of a qualifyinghands-on CPR certification as required. Employees identified as lacking therequired documentation or training will be immediately enrolled in the nextavailable hands-on CPR course and will be required to complete the trainingwithin the established timeframe.	
Y 0255 SS= E	NAC 449.217 6. A residential facility with **more than 10 residents** must: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Division and the state and local fire safety authorities.	Y 0255	The identified cleaning deficiencies were addressed bythe end of day on **July 22, 2026**, upon identification by thesurvey team. The designated areas were immediately cleaned and brought intocompliance, as evidenced by **Exhibits A–F** in the pdf provided. **Violation 1a – Ice Machine Biofilm:** Pink biofilm buildup identified in the ice machine was addressed on July 22,2026. The ice machine was completely drained, thoroughly cleaned with soap andwater, and then sanitized using an appropriate sanitizer solution. **Violation 1b – Ice Scoop Storage in Memory Care:** An ice scoop was placed in the Memory Care refrigerator on July 22, 2026, toensure proper handling and distribution of ice. To reinforce compliance,signage was posted	07/23/2026

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	Inspector Comments: Based on observation on 07/22/2026, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. There was pink biofilm build-up on the internal components of the ice machine in the main kitchen. b. Ice was stored in plastic bags in the memory care freezer and was not dispensed by using a scoop. Caregiving staff indicated ice was dispensed by pouring from the bag or by grabbing ice with gloved hands. c. The following non-food contact surfaces were soiled with grease and/or debris build-up: the cook's line ventilation hood filters; the sides of and behind cook's line equipment; electrical outlets near the waffle maker; and milk crates. d. Both dumpster enclosures were soiled debris, seepage and spider webs. e. The floor of the walk-in freezer was soiled with ice cream spillage. There was grease and debris on the floor of the cook's line. The floors were soiled with debris under shelving units. f. The floor sink in the bistro was heavily soiled with black grime build-up and a foul odor was present. Severity: 2 Scope: 2		on the Memory Care freezer reminding staff to use thedesignated ice scoop and notify dining services if the ice supply needs to berefilled. Ice will also be maintained in a covered container with a lid as anadditional precaution. **Violation 1c – Soiled Non-Food Contact Surfaces:** The identified soiled non-food contact surfaces were cleaned on July 22, 2026,using appropriate cleaning and sanitizing solutions. The kitchen hoods wereprofessionally cleaned on June 22, 2026, and will continue to be professionallycleaned on a 90-day rotation**.** The identified outlets and milkcrates were also thoroughly cleaned and sanitized. **Violation 1d – Dumpster Enclosures:** Both dumpster enclosures were swept and cleaned on July 22, 2026, uponidentification of the deficiency. **Violation 1e – Walk-In Freezer Floor:** The soiled area of the walk-in freezer floor, including the identified icecream spillage, was thoroughly cleaned on July 22, 2026, using an appropriatecleaning and sanitizing solution. **Violation 1f – Bistro Floor Sink:** The floor sink located in the Bistro was thoroughly cleaned and sanitized onJuly 22, 2026, using an appropriate sanitizing solution. **Ongoing Monitoring and Prevention:** Moving forward, to ensure continued compliance, the Dining Services Director will incorporate routinecleaning checks of the identified areas into the Dining Department'sestablished cleaning routine. The Dining Services Director will routinelyreview cleaning logs to verify that required cleaning tasks have been completedand will promptly address any identified deficiencies. The Executive Director will provide oversight to ensure theestablished cleaning and monitoring processes are consistently followed andmaintained.	

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Y 0690 SS= D	**NAC 449.2712 Residents requiring use of oxygen.** 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his need for oxygen; and (2) Administering the oxygen to himself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks.	Y 0690	Resident #15's oxygen tanks have been secured using additional oxygen tank storage racks, correcting the identified deficiency, see Exhibit 1 for documentation of oxygen properly stored. Resident #15 is no longer a resident in the community. To prevent recurrence, the community has implemented a revised process for the delivery and storage of oxygen supplies. Effective immediately, vendors delivering oxygen supplies will be required to check in at the front desk prior to making deliveries. Front desk staff will notify a medication technician, nursing department leader, or the Executive Director before the vendor proceeds with the delivery. A designated community representative will be present during delivery to verify that oxygen tanks are properly secured and stored in accordance with community policy before the vendor leaves the community. To identify and correct other areas that may be affected by the same deficient practice, the community Assisted Living Coordinator and Memory Care Coordinator completed an audit on 8/12/2026 of occupied resident rooms, to identify residents with oxygen in use, Exhibit 3. The audit verified that oxygen tanks are properly secured and that the required "Oxygen" notification is posted on the resident's door. No deficiencies were identified at the time of the audit. Attached is the blank version of the tracker used to determine residents with oxygen, labeled Chart Audit. To ensure ongoing compliance, the Assisted Living Coordinator and Memory Care Coordinator will complete monthly audits of occupied resident rooms where oxygen is in use to verify that oxygen tanks remain properly secured and that required door notifications are present. Audit findings will be reviewed with the Executive Director, and any identified deficiencies will be corrected immediately. The Executive Director will be responsible for oversight of	08/05/2026

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	(5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. 3. The administrator of a residential facility shall ensure: (a) The caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen; and (b) All caregivers are trained and knowledgeable regarding hazards and precautions to take when oxygen is in use. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secure for 1 of 25 sampled residents. (Resident #15) Findings include: Resident #15 (R15) R15 was admitted on 08/11/25, with a diagnosis including hypertension, congestive heart failure, hypertension, and hypothyroidism. On 07/22/26 in the morning, there were six oxygen tanks unsecured in room 240 (Resident #15). Two small tanks and four large tanks were stored against the wall in living area of R15's room. On 07/22/26 in the morning, the Administrator acknowledged the six tanks in R15's resident room should have been		these tasks. The Assisted Living Coordinator will be responsible for ensuring compliance within the Assisted Living neighborhood, and the Memory Care Coordinator will be responsible for ensuring compliance within the Memory Care neighborhood. The Executive Director will oversee implementation of the Plan of Correction and review monthly audit results to ensure continued compliance.	

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	secured. Severity: 2 Scope: 1			
Y 0840 SS= D	**NAC 449.2738** **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 449.2712 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	Y 0840	A new assessment was completed for Resident #10, which resulted in the determination that the resident would transition to the community's Memory Care neighborhood. Resident #10's move to Memory Care will be completed on August 15, 2026, correcting the identified deficiency. To prevent recurrence, the community has implemented a revised process for reviewing information obtained from annual placement assessments and physician forms. Moving forward, information provided through annual placement assessments and physician forms will be reviewed during the community's Care Team Conferences with nursing leadership and/or the Executive Director to ensure the resident's current placement form and annual physician assessment are accurately evaluated and addressed. Any changes identified during the review will be addressed, if applicable, promptly by nursing leadership and/or the Executive Director. The Executive Director will be responsible for oversight of these tasks.	08/15/2026

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	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. Inspector Comments: Based on observation, document review, record review and interview, the Bureau of Health Care Quality and Compliance (BHCQC) determined a current review by a physician of the physical and mental condition of 1 of 25 sampled residents was necessary (Resident #10). Findings include: Resident #10 (R10) R10 was admitted to the assisted living side of the facility on 02/10/25, with diagnoses including end stage Alzheimer's disease and depression. A Physician's Standard Placement Determination dated 04/13/26 documented R10 required a residential facility which provided care to persons with Alzheimer's disease or a related disease. The Placement Determination went on to document the resident should be placed in a facility that has protective supervision with wander control systems including restricted egress and have staffing requirements of at least 1 caregiver to 6 residents. On 07/22/26 in the morning, the Administrator acknowledged R10's 04/13/26 Physician's Placement Determination documented R10's Advanced Practice Registered Nurse (APRN) selected an Alzheimer's facility as an appropriate placement for R10. On 07/22/26 in the afternoon, a mini cognitive assessment of R10 was performed. When asked what city and state			

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	R10 lived in, R10 responded, “cha cha.” R10 reported the year was “cha cha” and verbalized the current President of the United States was named “cha cha.” R10 was unable to determine the day of the week it was. Therefore, due to the physician's assessment on 04/13/26, R10's diagnoses, the BHCQC's mini cognitive assessment, an assessment of the physical and mental condition of R10 was determined to be necessary by the BHCQC. Severity: 2 Scope: 1			
Y 0850 SS= D	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 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	Y 0850	Resident #6's annual physician examination was completedon July 22, 2026, correcting the identified deficiency. To prevent recurrence, the community has implemented arevised process for tracking annual physician examinations. Effectiveimmediately, annual physician examination forms will be sent to each resident'shealthcare provider sixty (60) days prior to the resident's annual examinationdue date to allow adequate time for completion and return of the requireddocumentation. To identify and correct other areas that may be affectedby the same deficient practice, the Assisted Living Coordinator and Memory CareCoordinator completed an audit of current resident records to identify anymissing or overdue annual physician examinations. Resident’s identified asmissing the required documentation will have the annual physician examinationform submitted to the resident's healthcare provider for completion in a timely manner. To ensure ongoing compliance, the community willmaintain a resident chart audit tickler system to monitor annual physicianexamination completion. The AssistedLiving Coordinator and Memory Care Coordinator will maintain the tracker, andthe Executive Director will have real-time access to review	07/22/2026

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	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 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.		compliance.Residents with annual physician examinations due within the next sixty (60)days will be reviewed during weekly leadership meetings to monitor the status ofoutstanding documentation, ensure timely follow-up with healthcare providers,and verify completion before the due date. The Executive Director will beresponsible for oversight of these tasks. The Assisted Living Coordinator will be responsible forsubmitting annual physician examination forms to healthcare providers andfollowing up to obtain completed documentation for Assisted Living residents.The Memory Care Coordinator will be responsible for submitting annual physicianexamination forms and following up with healthcare providers for Memory Careresidents. The Executive Director will oversee implementation of the Plan ofCorrection and review the resident chart audit tracker during weekly leadershipmeetings to ensure ongoing compliance.	

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	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 record review and interview, the facility failed to ensure 1 of 25 residents had an annual physical examination. (Resident #6) Findings include: Resident #6 (R6) R6 was admitted on 02/10/25 with a diagnosis of degenerative disc disease. On 07/22/26 in the morning, R6's file revealed R6 last received a physical examination on 02/10/25. R6’s file lacked documented evidence of a 2026 physical examination for R6. On 07/22/26 in the afternoon, the Administrator acknowledged R6's file did not contain evidence of an annual physical examination. Severity: 2 Scope: 1			

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Y 0874 SS= F	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. <u>The report must be reviewed and initialed by the administrator.</u> Inspector Comments: Based on interview and record review, the facility failed to ensure completed six-month medication reviews were reviewed and signed off by the administrator within 72 hours of completion, for 12 of 12 residents. Findings include: On 07/22/26 in the morning, review of six-month medication reviews dated 07/23/26 for 12 sampled residents, did not document the administrator reviewed and initialed the medication reviews within 72 hours of completion. On 07/22/26 in the afternoon, the Executive Director confirmed six-month medication reviews for 12 sampled residents were not reviewed and signed off by the administrator within 72 hours of completion. Severity: 2 Scope: 3	Y 0874	Documentation of the signed February 2026 medicationreviews was obtained from the previous Executive Director and submitted to theState for review, correcting part of the identified deficiency within twenty-fourhours. Medication reviews for August of 2025 were signed by previousadministrator on 8/13/2026. To prevent recurrence, the community has implemented a revised process forcompleting and maintaining medication review documentation. The ExecutiveDirector will be responsible for reviewing and signing medication reviewdocuments within seventy-two (72) hours of receipt from the pharmacy.Medication reviews will be completed during the required review periods inFebruary and August of each year. A designated medication review binder will bemaintained to securely organize all completed medication review documentation,ensuring records are readily accessible for review by authorized personnel andregulatory agencies.	08/13/2026
Y 1035 SS= E	NAC 449.2768 **Residential facility which provides care to persons with Alzheimer's disease:**	Y 1035	Attached are employees 5, 6, and 16 dementia training. **Employee number 17 no longer works with the community.** To prevent recurrence, the community has implemented a revised dementia training	08/14/2026

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	Alzheimer's/dementia Training: 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 is initially employed at the facility, at least 2 hours of tier 2 training. (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. (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). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to		compliance process. Effective August 10, 2026, new hires will be required to complete an additional day of education prior to attending new hire orientation. This training will include two (2) hours of dementia education. Employees will not be permitted to attend new hire orientation until the required training has been successfully completed. The Administrative Assistant will maintain the dementia training compliance tracker and tickler system, monitor training completion, and notify department leaders once employees have successfully completed the required dementia training and are eligible to attend new hire orientation. The Executive Director will be responsible for oversight of these tasks. To identify and correct other areas that may be affected by the same deficient practice, employees hired within the last 90 days will complete the required two (2) hours of dementia training by August 23, 2026, ensuring continuity of education provided.	

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	this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on record review and interview, the facility failed to ensure 5 of 15 sampled employees obtained 1) two hours of Alzheimer's training within the first 40 hours of employment, 2) eight hours of Alzheimer's training within the first 90 days of employment, or 3) three hours of Alzheimer's training annually (Employees #5, #6, #13, #16, and #17). Findings include: Employee #5 (E5) was hired on 02/19/26 as a Caregiver. E5 received a total of eight hours of Alzheimer's training on 03/11/26. E5's file lacked documented evidence E5 received an additional two hours of Alzheimer's training within the first 90 days of employment. Employee #6 (E6) was hired on 01/27/26 as a Caregiver. E6 received a total of eight hours of Alzheimer's training on 02/04/26. E6's file lacked documented evidence E6 received an additional two hours of Alzheimer's training within the first 90 days of employment. Employee #13 (E13) was hired on 05/13/26 as a Medication Technician (Med Tech). E13 received three hours of initial Alzheimer's training on 05/26/26. Two hours of Alzheimer's training was not completed within the first 40 hours of employment. Employee #16 (E16) was hired on 06/14/25 as a Caregiver. E16 received a total of eight			

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	hours of Alzheimer's training on 07/02/25. E16's file lacked documented evidence E16 received an additional two hours of Alzheimer's training within the first 90 days of employment and three hours of Alzheimer's training annually. Employee #17 (E17) was hired on 06/18/24 as a Med Tech. E17 received a total of eight hours of Alzheimer's training on 07/10/24. E17's file lacked documented evidence E17 received an additional two hours of Alzheimer's training within the first 90 days of employment and three hours of Alzheimer's training annually. On 07/23/26 in the afternoon, the Administrator acknowledged the facility lacked documented evidence the employees had completed the required Alzheimer's training and indicated the additional required training had not been completed. Severity: 2 Scope: 2			
Y 1840 SS= D	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of	Y 1840	Employee #7 completed the required Infection Controltraining on August 7, 2026, correcting the identified deficiency. Employee #16 wascompleted on May 11, 2026, but missing from chart. To prevent recurrence, the community has implemented arevised Infection Control training compliance process. Effective August 10,2026, current employees will be assigned the required annual Infection Controltraining sixty (60) days prior to their annual renewal date, based on theirhire date, to ensure adequate time for completion before the training expires.Employees with training due within the next sixty (60) days will be notified ofthe upcoming training requirement, and department leaders will receivebi-weekly compliance reports identifying employees with upcoming or outstandingtraining requirements. Effective August 10, 2026, new hires will be required tocomplete the initial Infection	08/07/2026

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	completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 19 sampled employees completed the initial and/or annual required infection control training for unlicensed caregivers (Employee #7 and #16). Findings include: Employee #7 (E7) E7 was hired on 06/04/2025 as a Caregiver. E7's file lacked documented evidence of an initial infection control training for unlicensed caregivers through a nationally recognized organization within a year of employment. Employee #16 (E16) E16 was hired on 06/04/2025 as a Caregiver. E16's file documented an infection control training dated 07/02/2025. E16's file lacked documented evidence of 2026 annual infection control training for unlicensed caregivers through a nationally recognized organization. On 07/22/2026 in the afternoon, the Executive Director acknowledged E7 and E16's missing initial and/or annual infection control trainings and was unable to provide the documentations. Severity: 2 Scope: 1		Control training prior to attending New HireOrientation. The Administrative Assistant will maintain the InfectionControl training compliance tracker and tickler system, assign and monitor bothinitial and annual Infection Control training, notify employees of upcomingtraining requirements, and distribute bi-weekly compliance reports todepartment leaders. The training compliance tracker will be reviewed duringweekly leadership meetings to verify compliance, address outstanding trainingrequirements, and ensure timely completion. Department leaders will be responsiblefor ensuring employees complete all required Infection Control training by theassigned due date. The Executive Director will be responsible for oversight ofthese tasks. To identify and correct other areas that may be affectedby the same deficient practice, the community completed an audit of currentemployee training records to verify that each employee has documentation of therequired initial and annual Infection Control training, as applicable. Anyemployee identified as missing the required training or documentation will beassigned the required training and will complete it by August 21, 2026.	