STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	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 03/25/2026. The facility is licensed for 72 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was 36. 10 resident records and 10 employee records were reviewed. The facility received a grade of D.			
Y 0051 SS= C	**NAC 449.194** 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge.	Y 0051	Executive Director to monitor and post in writing the designee during the absence of the Executive Director. Executive Director to monitor through QA process.	03/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	**2121 EAST PRATER WAY, SPARKS, NEVADA ,89434**

(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
	Inspector Comments: Based on observation and interview, the facility failed to designate, in writing, one or more active employees to oversee the facility during the Administrator's absence and post the names in a public place within the facility, potentially affecting 36 of 36 residents. Findings include: On 03/26/2026 at 9:15 AM, a posting documented the facility designee as an employee no longer employed by the facility. On 03/26/2026, at 3:30 PM, the Wellness Director confirmed the posting lacked the name of an active employee and verbalized the former employee, designated on the posting, was terminated on 02/13/2026. Severity: 1 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
Y 0102 SS= D	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on employee record review and interview, the facility failed to ensure an employee obtained a pre-employment physical examination for 1 of 10 employees (Employee #5). The deficient practice placed residents at risk from employee(s) not completing all eligibility requirements prior to providing care to residents. Findings include: Employee #5 Employee #5 was hired as a Medication Technician on 01/06/2026. Employee #5's record documented a pre-employment physical examination was completed on 08/02/2024, 17 months prior to the hire date. On 03/25/2026 at 3:00 PM, the Administrator verbalized Employee #5 had been previously employed as a Medication Technician who had left employment for approximately four months. Upon re-hire, Employee # 5 was not asked for a new pre-employment physical. Severity: 2 Scope: 1	Y 0102	Business Office Director to oversee all new hire physicals are completed upon hire. Executive Director to audit through QA process.	03/30/2026
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are	Y 0172	Housekeepers and Wellness Coordinator to monitor environmental rounds daily. Any findings will be corrected immediately to appropriate departments. Wellness Director and Maintenance Director to oversee process. Executive director and Wellness Director to monitor through QA process.	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, facility failed to ensure, to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	extent practicable, the premises of the facility must be kept free from offensive odors, affecting 36 of 36 residents. Findings include: On 03/25/2026 at 7:55 AM, a strong odor, similar to ammonia-like/musty/slightly sour, was noted in the central area which included the dining area where residents were consuming breakfast. The odor carried into the northwest corridor. On 03/25/2026 at 9:50 AM, similar odors were identified in Room 57 and at 10:12 AM in Room 28. When in Room 28, the Maintenance Director (MD) verbalized each room was cleaned by housekeeping, four days per week, which could contribute to the odor. Severity: 2 Scope: 3			
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar	Y 0250	The dishwasher temperature gauge was replaced and fixed on 3-30-26. Dining Services Director and cooks to maintain use of sanitation buckets (Quat solution). DSD to oversee through weekly audits. Executive Director to audit through QA process.	03/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure sanitization buckets were maintained in the kitchen area and the dishwasher was operating at required temperature. Findings include: On 03/25/2026 at 8:30 AM, during a tour of the kitchen, the following was observed: -A Quaternary (Quat) solution, utilized to allow for the sanitary preparation of food, had not been readied or deployed to any of the facility's kitchen preparation, work, or serving area locations. -The temperature gauge used to reflect the operating water temperature of the kitchen's low temperature dishwasher was obscured, by an unknown substance or buildup on the gauge, and did not appear to fluctuate its temperature reading during dishwasher operation. On 03/25/2026, at 8:50 AM, the cook verbalized the cook tries to prepare Quat buckets for use when the cook arrives for duty at 6:00 AM; however, had not completed the task this date and had not used the sanitary solution normally contained within the buckets. On 03/25/2026, at 10:10 AM, the Dining Services Director (DSD) verbalized that a Quat solution should have been readied and deployed to maintain sanitary conditions in the kitchen area. On 03/25/2026, at 10:16 AM, the DSD operated the kitchen's low temperature dishwasher and confirmed the water temperature gauge did not appear			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	functional. The DSD verbalized the DSD did not know the actual water temperature inside the dishwasher during its operation. The DSD believed dishwasher water temperature should reach at least 120 degrees. The facility policy titled, “Daily Dish Machine Temperature Log” documented, the temperature of a wash solution in spray-type ware washers that use chemicals to sanitize may not be less than 120 degrees Fahrenheit. On 03/25/2026, at 3:20 PM, the Wellness Director communicated the facility had no sanitation policy for its kitchen. Severity: 2 Scope: 3			
Y 0515 SS= E	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	Y 0515	Resident #1,#6, #9 were corrected and resident #7 no longer resides in community. Wellness Director to oversee individual care plans are signed at time of scheduled care plan meeting. Executive Director to monitor through QA process.	04/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	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 resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to have a resident or their responsible party, and Administrator signatures on initial person-centered service plans for 4 of 10 sampled residents (Resident #1, #6, #7, and #9) Findings include: Resident #1 Resident #1 was admitted to the facility on 07/29/2025, with diagnoses of dementia, depression and hypertension. Resident #1's person centered service plan dated 09/16/2025, lacked signatures from			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	the resident or responsible party and, the Administrator. On 03/25/26 at 1:26 PM, the Health and Wellness Director, confirmed Resident #1s initial person-centered service plan, dated 09/16/2025, lacked signatures from the resident or responsible party, and the Administrator. On 03/25/2026 at 1:31 PM, the Administrator, confirmed Resident #1s initial person-centered service plan, dated 09/16/2025, lacked signatures from the resident or responsible party, and the Administrator. Resident #6 was admitted to the facility on 12/28/2021, with diagnoses of dementia, anxiety, and hypertension. Resident#7 was admitted to the facility on 07/14/2022, with diagnoses of dementia, gastroesophageal reflux disease, and hypertension. Resident#9 was admitted to the facility on 08/05/2021, with diagnoses of Alzheimer's disease, major depressive disorder, and prostate cancer. On 03/25/2026, Resident #6's, #7's, and #9's service plans lacked signatures of the Wellness Director (WD) and the representative of each resident. On 03/25/2026, the WD confirmed the service plans were lacking the resident representative signature and the Wellness Director's signature. Severity: 2 Scope: 2			
Y 0522 SS= D	NAC 449.259 (k) If the resident has Alzheimer’s disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility,	Y 0522	All service plans were reviewed and updated as needed to reflect current care needs. Resident #7 no longer resides in community. The Administrator or designee will review service plans to ensure compliance is met	07/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if: (I) It is determined through an assessment conducted pursuant to paragraph (c) of subsection 1 of NRS 449.1845 that the resident meets the criteria prescribed in paragraph (a) of subsection 2 of that section; and (II) The facility does not meet the requirements of NAC 449.2754 or 449.2756 or is otherwise unable to properly care for the resident. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure a person-centered service plan (care plan) contained interventions for a resident with dementia/memory loss for 1 of 10 sampled residents (Resident #7). Findings include: Resident #7 Resident#7 was admitted to the facility on 07/14/2022, with diagnoses of dementia, gastroesophageal reflux disease, and hypertension. Resident #7's clinical record contained a care plan initiated on 08/09/2024; however, the care plan lacked interventions for the care and treatment of dementia/memory loss. On 03/25/2026 at 1:30PM, the Wellness Director verbalized the required components of a care plan were focus, goals, and interventions. The Wellness Director explained a care plan was created for a specific purpose and should have interventions listed. The Wellness Director confirmed the care plan for Resident #7 lacked interventions for dementia/memory loss.		through QA process for all new move-ins and scheduled 6 month assessments and or change of condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	Scope: 2 Severity: 1			
Y 0878 SS= D	NAC 449.2742 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	Y 0878	Resident #2 OTC was destroyed on 3-25-26. Wellness Director to audit medication carts weekly. Executive Director to monitor through QA process.	03/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure a resident's over-the-counter medication/dietary supplement was given only if the resident's physician, physician assistant or advance practice registered nurse had approved the administration of the medication or supplement in writing for 1 of 10 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/10/2025, with diagnoses including dementia, debility, and endocarditis. On 03/25/2026, Resident #2's medications included, a bottle labeled Spring Valley quick-dissolve vitamin B-12 supplement 2,500 microgram (mcg) tablets. The bottle label indicated 120 tablets; however, it appeared fewer tablets remained in the bottle at time of review. Resident #2's March 2026 Medication Administration Record (MAR) lacked documented evidence of a vitamin B-12 supplement. Additionally, the facility was unable to produce a current physician's order for the vitamin B-12. On 03/25/2026 at 12:46 PM, the Wellness Director (WD) verbalized family members			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	sometimes bring medications and supplements to the facility and suggested the vitamin B-12 was brought by family members in this case as there was no physician order approving the administration of the vitamin B-12 supplement. The WD also confirmed that the vitamin B-12 supplement was not included in the residents MAR and should not have been administered to the resident. The facility policy titled “Medication and Treatment Management” documented both over-the-counter and prescription medications must be authorized for staff assistance by the resident’s physician. Severity: 2 Scope: 1			
Y 0885 SS= D	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure a resident's discontinued medication was removed from the medication cart and destroyed for 1 of 10 sampled residents	Y 0885	Resident #6 medication was destroyed on 3 -25-26. Wellness Director to audit medication carts weekly. Executive Director to monitor through QA process.	03/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	(Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 12/28/2021, with diagnoses including dementia and anxiety. A physician's order dated 10/29/2025, for Meloxicam 7.5 milligrams (mg) oral tablet, take 1 tablet by mouth every day and discontinue on 02/04/2026. The medication was removed from Resident #6's March 2026 Medication Administration Record (MAR); however, was not removed from the facilities medication cart or destroyed. On 03/25/2026 at 12:46 PM, the Wellness Director (WD) verbalized Resident #6's Meloxicam had been discontinued; however, was not removed from the medication cart or destroyed as required. The facility policy titled "Disposition of Medication" documented discontinued medications would be destroyed. The facility policy titled "Controlled Substances" documented the procedure for the destruction of controlled substances. Severity: 2 Scope: 1			
Y 0890 SS= A	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	Y 0890	Wellness Director corrected and added Hyoscyamine Sulf 0.125mg SL tab ordered on 3-25-26 and added scheduled start date on 3-26-26. Wellness Director to monitor medications through weekly Med Cart Audit. Executive Director to monitor through QA process.	03/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	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; (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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure a resident's medication was included on the resident's Medication Administration Record (MAR) for 1 of 10 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 07/29/2025, with diagnoses including dementia, depression, and hypertension. A physician's order dated 01/05/2026, documented Hyoscyamine sub 0.125 milligrams (mg), place 1 tablet under tongue every 4 hours as needed for excess secretions. The order for Hyoscyamine was available on the medication cart; however, the medication was not listed on resident #1's March 2026 MAR. The PRN medication had not been administered to the resident. On 03/25/2026 at 12:46 PM, the Wellness Director (WD) verbalized the physician's order for the medication was still valid, and the medication was included on the hospice MAR; however, not on the facility's MAR. The WD verbalized the omission from the facility MAR was due to a processing error and acknowledged the medication should have been included in the facility MAR. On 03/25/2026 at 3:38 PM, the WD verbalized the facility had no policy related to MAR inaccuracies. Severity: 1 Scope: 1			
Y 0930 SS= D	NAC 449.2749 Maintenance and contents of separate file of information concerning each	Y 0930	Resident #6 and #9 ADL was completed by Wellness Director. Resident #7 no longer resides in community. Wellness Director to over see annual ADL	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	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 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		to be completed for each individual resident. Executive Director to Audit through QA process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	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 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	(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. 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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

Inspector Comments:

Based on interview and record review, the facility failed to ensure an Activities of Daily Living (ADL) Assessment was completed annually and signed for 3 of 10 sampled residents (Resident #6, #7, and #9)

Findings include:

Resident#6

Resident #6 was admitted to the facility on 12/28/2021, with diagnoses of dementia, anxiety, and hypertension.

Resident #6's ADL assessment dated, 09/17/2025 lacked documented evidence of signatures from the Wellness Director and the resident’s representative.

Resident #7

Resident#7 was admitted to the facility on 07/14/2022, with diagnoses of dementia, gastroesophageal reflux disease, and hypertension.

Resident#7's ADL assessment dated, 05/13/2025 was incomplete and lacked documented evidence of signatures from the Wellness Director and the resident’s representative.

Resident#9

Resident#9 was admitted to the facility on 08/05/2021, with diagnoses of Alzheimer's disease, major depressive disorder, and prostate cancer.

Resident#9's ADL assessment dated, 09/17/2025 lacked documented evidence of signatures from the Wellness Director and the resident’s representative.

On 03/25/2026 1:30 PM, the Wellness Director (WD) confirmed the facility used a template for the ADL assessment and the WD confirmed the templates were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	updated to accurately reflect the residents' care needs, and also the ADL needed to have signatures, to make it a legal medical document. Severity: 2 Scope: 1			
Y 1300 SS= C	**Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.]** 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national	Y 1300	The community website was updated to include the required nondiscrimination statement and complaint contact information. The Executive Director verified the information was posted accurately and is accessible to the public. Executive Director to review the website quarterly to ensure ongoing compliance.	06/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments: Based on observation and interview, the facility failed to ensure a non-discrimination statement with the contact information for filing a complaint was posted on the facility's Internet website, used to market the facility. Findings include: On 03/25/2026 at 2:00 PM, the facility's website, used to market the facility, lacked documentation of a non-discrimination statement and the contact information for the Division for filing a non-discrimination complaint. On 03/25/2026 at 2:28 PM, the Administrator confirmed the facility's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	website, used to market the facility, lacked a non-discrimination statement and the contact information for filing a complaint. The Administrator verbalized not having realized the information had not been posted to the website and confirmed it should have been. This was a repeat deficiency from the 04/29/2025 annual survey. Severity: 1 Scope: 3			
Y 1825 SS= F	**NAC 449.0109 Designation and training of person responsible for infection control.** 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually	Y 1825	Executive Director and Maintenance Director completed the mandatory 15 hours of Infection Control Training. Business Office Director to oversee annual Infection Control Training. Executive Director to Audit through QA process.	04/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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
	thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and the secondary infection control manager completed 15 hours of infection control training annually (Employee #1 and Employee #4). Findings include: Employee #1 Employee #1 was hired as the Executive Director on 07/01/2024 and was designated as the primary infection control manager. On 03/25/2026, Employee #1's personnel file documented the employee had last completed 15 hours of infection control training on 09/23/2024; however, lacked infection control training by 09/23/2025. Employee #4 Employee #4 was hired as the Maintenance Director on 09/30/2024 and was designated at the secondary infection control manager. On 03/25/2026, Employee #4's personnel file documented initial training was completed on 11/08/2024; however, the annual training was not completed until 02/20/2026, three-months beyond the required annual date. On 03/25/2026 at 2:30 PM, the Administrator confirmed the 15 hours of infection control training had not been completed, annually, as required.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	**2121 EAST PRATER WAY, SPARKS, NEVADA ,89434**

(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