Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9735	A. BUILDING _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MESA VALLEY ESTATES	1328 BERTHA HOWE AVE, MESQUITE, NEVADA ,89027

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 01/14/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 103 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease and/or Assisted Living Services, Category II residents. The census at the time of the survey was 63. Fifteen resident files and eight employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

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0053 SS= E	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on interview and record review, the facility failed to ensure resident's physical exams were complete and accurate for 5 of 15 residents (Resident #1, Resident #2, Resident #4, Resident #5 and Resident #6). Findings include: Resident #1 (R1) R1 was admitted on 11/27/24. Review of R1's physical exam dated 11/27/24 did not list a diagnosis for R1. Resident #2 (R2) R2 was admitted on 03/31/22. Review of R2's physical exam dated 02/03/24 did not list a diagnosis for R2. Resident #4 (R4) R4 was admitted on 10/02/21. Review of R4's physical exam dated 12/03/24 did not list a diagnosis for R4. Resident #5 (R5) R5 was admitted on 06/28/24. Review of R5's physical exam dated 06/25/24 did not list a diagnosis for R5. Resident #6 (R6) R6 was admitted on 07/31/24. Review of R6's physical exam dated 07/31/24 did not list a diagnosis for R6. On 01/14/24, in the morning, the Wellness Director confirmed the physical exams were incomplete and did not list diagnoses for R1, R2, R4, R5 and R6. Severity: 2 Scope: 2	0053	0053 •□□□□□□□□Physicians for Residents #2, #4, #5, and #6 were contacted when the Confidential Resident/Employee Identifier List was provided(1/18/25) to provide new H&P with diagnosis included. Resident #2 attended an appointment with her provider on 2/06/25 1:30p for H&P, but updated H&P has still not been provided to Facility. Resident #4 saw provider, new H&P was updated, complete with diagnosis (see attached). Resident #5 was scheduled for the soonest possible appointment with her provider, 2/26/25 1:40a (see attached). Resident #6 was scheduled for the soonest possible appointment with her provider, 2/26/25 11:20a (see attached). •□□□□□□□□Resident #1 expired 1/30/25, the provider did not create new H&P by the time she expired. •□□□□□□□□The Wellness Director under the supervision of the Administrator will conduct H&P audits upon each resident quarterly evaluation to ensure diagnosis are included in each resident H&P. •□□□□□□□□H&P audits/resident evaluations are conducted quarterly, within 3 months (6/10/25), all resident H&Ps will be audited for diagnosis.	02/10/2025

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0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 01/14/2025, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. One container of yogurt was expired on 12/03/24 in the bottom portion of the deli refrigeration and one container of yogurt was expired on 01/06/25 in the reach-in refrigerator. 2. Major Violations: a. Bowls, which did not have handles, were used as scoops and stored in containers of bulk product such as cereals, rice and sugar. b. There was grime build-up on the interior plastic shield of the ice machine. Severity: 2 Scope: 2	0255	•□□□□□□□□The two expired yogurts were discarded the same day as discovered (01/14/25). •□□□□□□□□The Dining Director under supervision of the Administrator will conduct audits for potentially expired items. •□□□□□□□□The audits are being conducted daily. •□□□□□□□□The bowls which were in the containers were replaced with handled scoops same day as discovered (01/14/25). •□□□□□□□□The Dining Director under supervisor of the Administrator will conduct audits to ensure the appropriate handled scoops are being utilized for bulk product. •□□□□□□□□The scoop audits are being conducted daily. •□□□□□□□□The grime build-up on the interior of the ice machine was cleaned up the same day as discovered (01/14/25). •□□□□□□□□The Dining Director under the supervisor of the Administrator will conduct audits for potential build-up. •□□□□□□□□The audits are being conducted daily.	01/14/2025
1600 SS= F	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in	1600	•□□□□□□□□Upon evaluations, each resident will be asked which preferred pronouns. The preference will be reflected on the resident's individual care plan. •□□□□□□□□The Wellness Director under the supervision of the Administrator will ensure residents' pronoun preference	02/10/2025

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	accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility lacked updated policies and procedures addressing the resident's preferred pronoun, gender expression and sexual orientation for 8 of 15 residents. (Residents #2, #4, #5, #6, #8, #10, #11 and #12). Findings include: A review of the resident records revealed the facility lacked updated forms which included a process and procedure to document the resident's gender identification or expression in their medical/resident/patient records. There were eight out of 15 residents files that did		reflects on the resident care plan. •□□□□□□□□Resident evaluations are conducted quarterly, within 3 months (6/10/25), all resident H&Ps will be audited for preferred pronouns.	

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	not include documentation of preferred pronoun, gender expression and sexual orientation. On 01/14/25 in the morning, the Wellness Director confirmed there was no documentation of R2, R4, R5, R6 and R8, R10, R11 and R12's preferred pronoun, gender expression and sexual orientation and had not added this information to their admission documents. Severity: 2 Scope: 3			