

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and document review, the facility failed to ensure dishware was sanitized by facility policy in the three-compartment sink of the main kitchen. This deficient practice had the potential to cause spreading foodborne illnesses exposing all residents who received meals from the kitchen. Findings Include: On 01/27/2026 at 7:48 AM, the quaternary ammonium sanitizer solution in the three-compartment sink measured approximately 50-100 parts per million (ppm), indicating the sanitizer solution in the three-compartment sink was low. On 01/28/2026 at 7:30 AM, the Food Service Manager indicated the quaternary ammonium sanitizer solution should be maintained between 200-400 ppm as per most health and food safety standards and manufacturer guidelines. The Food Service Manager stated the proper cleaning process included washing, rinsing, and sanitizing all utensils and equipment. The Food Service Manager stated the three-compartment sink must be tested daily. The facility's policy of titled Manual Cleaning and Sanitizing with a Three-Compartment sink, dated 10/15/2025, documented immersion for at least one minute in a clean solution of 150-200 ppm of quaternary ammonium 75 Fahrenheit or hotter.</p> |                                                                                         |                                                 |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                         |                                                 |
| F 0552<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review and document review the facility failed to ensure informed consent was obtained prior to administration of psychotropic medications for 1 of 48 sampled residents (Resident 14). The deficient practice had the potential for the residents to not be informed of risk, benefits, and potential side effects of the medication. Findings include: Resident 14 (R14) was admitted on [DATE] with diagnoses including metabolic encephalopathy, depression, and unspecified mood disorder. A Physician Order dated 01/12/2026 documented Duloxetine (an antidepressant medication) capsule, delayed release, 30 milligrams (mg) twice a day. R14's medical record lacked documented evidence informed consent was obtained prior to the first administration of duloxetine on 01/12/2026. On 01/28/2026 at 4:40PM, the Director of Nursing (DON) confirmed R14's medical record lacked consent for Duloxetine. On 01/29/2026 at 10:34 AM, a Licensed Practical Nurse (LPN) explained a consent for psychotropic medication was required prior to the administration of the medication. On 01/30/2026 in the afternoon, the Director of Nursing explained the expectation was for staff to obtain a consent for psychotropic medication prior to administration. The facility policy titled Medication Management, Psychotropic Drugs-Use of, revised 04/17/2025 documented a consent form would be completed for each psychotropic medication prescribed.</p> |                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                 |
| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, and document review, the facility failed to ensure a comprehensive person-centered care plan for activities was created for 1 of 48 sample residents (Resident 1). The deficient practice had the potential for residents not to receive care and services in accordance with assessed needs. Findings include:Resident 1 (R1) was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, pleural effusion, and hypothyroidism. R1 was on contact isolation.On 01/27/2025 in the morning, R1 enjoyed working on puzzles. R1 had not attended activities and was unaware of what activities the facility offeredR1's medical record lacked a care plan for activities which outlined specific interventions with measurable goals to promote R1's quality of life.On 01/30/2026 at 9:30 AM, an Activity Aide completed an activity assessment for R1 upon admission. The Activity Aide was unaware of the staff member responsible for completing the activity care plan.On 01/30/2026 at 9:35AM, the Minimum Data Set (MDS) Director confirmed R1 lacked an activity care plan and explained the activity care plan should have been completed within 14 days of admission and was unaware of the staff member responsible for completing the activity care plan.The facility policy titled Care Plan Process, Person-Centered Care, revised 05/05/2023, documented person-centered care plan includes trying to understand what each resident was communicating and identifying what was important to each resident regarding daily routines and preferred activities.</p> |                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                 |
| F 0684<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review and document review, the facility failed to obtain a physician order for the use of a knee brace for 1 of 48 sampled residents (Resident 14). The deficient practice had the potential to result in discomfort, impaired circulation or skin breakdown. Findings include: Resident 14 (R14) was admitted on [DATE] with diagnoses including metabolic encephalopathy, depression, displaced transverse fracture of left patella, and unspecified mood disorder. On 01/27/2026 in the morning, R14 had knee brace lying on top of the dresser located at the foot of R14's bed. A Physician Order dated 11/24/2025 documented Restorative Nursing Services: passive range of motion to left lower affected side, non-weight bearing left lower side, active range of motion to upper extremities and to unaffected lower right side, at least 6 days per week. On 01/30/2025 at 9:18 AM, the Restorative Nurse Assistant (RNA) explained R14's knee brace originally came from physical therapy, and the brace was applied by RNA services. The RNA explained R14 frequently refused the use of the brace due to pain and would yell for the brace to be removed. R14's medical record lacked a physician order, RNA notes, and care plan for the knee brace. On 01/30/2026 in the morning, the Medical Records Director confirmed R14's medical record lacked documentation of RNA services provided, a physician order for the knee brace. On 01/30/2026 at 9:22AM, the Unit Manager confirmed R14 required a physician order for knee brace. The facility policy titled Physician Orders, revised 05/05/2023, documented the facility has physician orders for the resident's immediate care to include but not limited to routine care orders to maintain or improve the resident's functional abilities. The facility policy titled Restorative Nursing, revised 10/25/2024, documented restorative program approaches and interventions are included in the plan of care. The interventions and results are documented.</p> |                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                 |
| <p>F 0759</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, and document review the facility failed to ensure it was free of a medication error rate of less than five percent (%) for 2 of 48 sampled residents (Resident 74 and Resident 86). The deficient practice posed a potential risk of injury or harm to the residents. Findings include: On 01/29/2026 in the morning, a Medication Administration Pass observation was performed with 28 opportunities observed with two errors. The medication error rate was 7.14%. 1) Resident 74 (R74) was admitted on [DATE] with diagnoses including displaced fracture of lateral condyle of left femur, unspecified protein calorie malnutrition, and atrial fibrillation. On 01/29/2026 at 7:50AM, during the Medication Administration Pass observation the Licensed Practical Nurse (LPN) prepared and administered R74's scheduled morning medications. A Physician Order dated 01/07/2026 documented Azelastine spray 137 micrograms (mcg), two nasal sprays once a day at 8:00AM. R74's Azelastine spray was not administered per physician order. On 01/29/2026 at 9:53 AM, the LPN confirmed the physician order for Azelastine spray and explained the medication had been overlooked and should have been administered as ordered. 2) Resident 86 (R86) was admitted on [DATE] with diagnoses including sarcopenia, pressure ulcer of right buttock stage three, and generalized muscle weakness. On 01/29/2026 at 8:57AM, during the Medication Administration Pass observation the LPN prepared and administered R86's scheduled morning medications. A Physician Order dated 01/01/2026 documented Lovenox 40 milligrams (mg) subcutaneously (SQ) once a day at 8:00AM. R86's Lovenox was not administered per physician order. On 01/29/2026 at 9:53AM, the LPN confirmed the physician order for Lovenox and explained the medication had been omitted and should have been administered as ordered. The facility policy titled Medication Management Program, revised 01/15/2025, documented the authorized staff member administers medications according to accepted standards of practice and incompliance with regulatory requirements.</p> |                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                 |
| F 0761<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review and document review the facility failed to 1) ensure medications were secured for 1 of 48 sampled residents (Resident 67) and 2) expired multi-dose vial of medication was disposed. The deficient practice had the potential risk of unauthorized access to medication, or misuse of medication within the facility and potential for the facility staff to administer expired medications. Findings include: 1) Resident 67 (R67) was admitted on [DATE] with diagnoses including recurrent dislocation of right hip, acute osteomyelitis of right femur, and fibromyalgia. On 01/27/2026 at 7:52 AM, R67 had one 10-ounce (oz) spray bottle of 91 percent (%) Isopropyl alcohol, a spray bottle of Hydrogen Peroxide, and one 10 oz bottle of Mylanta on the overbed table. On 01/30/2026 at 7:48 AM, R67 had one 10oz spray bottle of 91% Isopropyl Alcohol, a 10oz bottle of Mylanta, and one tube of Neosporin on top of the overbed table. R67 explained being able to use the Isopropyl Alcohol and Neosporin for skin scrapes and the Mylanta only if needed for heartburn. R67's medical record lacked a medication self-administration assessment and physician's order for 91% Isopropyl Alcohol, Mylanta and Neosporin. On 01/30/2026 at 7:50AM, the Director of Nursing (DON) confirmed findings and explained Certified Nurse Assistants (CNAs) and nurses should remove medications from the resident's bedside when observed. The DON explained the process for a resident to keep medications at bedside was to conduct a medication self-administration assessment and obtain a physician order for the medications to remain at bedside. 2) On 01/30/2026 at 8:20 AM, during a tour of the second-floor medication storage room with the Unit Manager, an open one milliliter (ml) multi-dose vial of Tuberculin Diluted Aplisol dated 11/27/22025 was in the medication refrigerator. The Unit Manager explained the medication should have been discarded within 30 days of opening. The facility policy titled Medication Storage, General Guidelines for Storage of Medication and Biologicals, revised 04/17/2024, documented outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock and disposed of according to procedures for medication destruction.</p> |                                                                                         |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>295110                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Green Valley Health and Wellness Suites                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2965 Wigwam Parkway<br>Henderson, NV 89074 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                 |
| F 0868<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee included the Medical Director. The deficient practice had the potential to delay quality improvement actions leading to problems going unaddressed, delayed correction actions or risks not being mitigated. Findings include: The Quality Assessment and Assurance Meeting Minutes documented the Medical Director did not attend on 01/16/2025, 03/27/2025, 04/25/2025, 05/22/2025, 06/24/2025, 08/28/2025, 10/16/2025 and 01/15/2026. On 01/30/2026 at 11:30 AM, the Administrator confirmed the Medical Director had not been attending the QAPI meetings. The Administrator explained the Medical Director had scheduling conflicts and did not attend the meetings at least quarterly. The facility's policy titled Leadership Framework revised 12/03/2019 documented the facility (QAA) committee team will meet at least monthly to meet the demands of identified facility needs and will be composed of at a minimum, the Administrator, Director of Nursing, Medical Director or Designee, Infection Control Officer, and individual in leadership role.</p> |                                                                                         |                                                 |