

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/03/2018
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 6650 W FLAMINGO RD, LAS VEGAS, NEVADA ,89103	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated in your facility on 12/12/17 and completed on 1/3/18. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for 100 Residential Facility for Group beds which provide assisted living services for elderly and disabled persons, and/or persons with mental illnesses or chronic illnesses, Category II residents. The census at the time of the survey was 96. Complaint #NV00050956 with three allegations was investigated. The complaint could not be substantiated. Allegation #1, regarding resident food preferences not honored could not be substantiated. Allegation #2, regarding a lack of activities could not be substantiated. Allegation #3, regarding resident rooms not cleaned properly could not be substantiated. The investigation into the three allegations included: -Interviews with four residents. -Interviews with the Cook, Director of Dining Services, Morning Shift Service staff, Activities Director and Administrator. -Review of facility Activities Calendar and game rules. -Review of facility Caregiver and Housekeeping Aide job descriptions. -Review of facility Residency Agreement. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were identified. No further action is required. Please retain this for your records.			

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

Title:

Date:

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.