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	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT VIEW SENIOR LIVING	**3890 N BUFFALO DRIVE, LAS VEGAS, NEVADA ,89129-8809**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 01/12/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 113. The sample size was six. There was one complaint investigated. The facility received a grade of A. Complaint #NV00067374 with eight allegations was unsubstantiated. Allegation #1, a resident was not given medications for two weeks was unsubstantiated based on review of Medication Administration Records of six residents which did not document any missed medications and interviews with a Medication Technician and the Wellness Director who indicated residents were given all medications as scheduled. Allegation #2, hygiene care including bathing was not done for a resident and a resident had a strong odor was unsubstantiated based on observation of well-groomed residents with good hygiene, lack of unpleasant odors and interviews with a caregiver, a Medication Technician, the Wellness Director and the Administrator who indicated residents received hygiene care daily and showers at least two times a week. Allegation #3, family members were denied visitation was unsubstantiated based on observation of a family visiting with a resident, interviews with a caregiver, a Medication Technician, the Wellness Director and the Administrator who indicated visitation was always allowed during visitation hours in residents rooms or in a private visitation area. Allegation #4, a resident was left wet and soiled in bed was unsubstantiated based on observation of residents who were clean and unsoiled, clean beds, absence of odors and interviews with a caregiver, a Medication Technician, the Wellness Director and the Administrator who indicated residents were checked on at least every two hours to	0000		

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

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	ensure they were cleaned and changed as needed. Allegation #5, a resident had unexplained injuries and the family was not informed of a change in condition was unsubstantiated based on review of incident reports for three residents, which documented family members were notified within one hour of an incident occurring and interviews with the Wellness Director and Administrator who indicated whenever an incident occurred the family and physician would be notified as quickly as possible. Allegation #6, a resident was made to wear other residents' clothes and residents' personal items were missing was unsubstantiated based on observation of residents wearing clothing which belonged to them and interviews with a caregiver and a Medication Technician who indicated residents clothes were labeled to ensure they were not wearing other residents' belongings. Allegation #7, staff are not properly trained was unsubstantiated based on record review of five staff members which documented all trainings were current and interviews with the Wellness Director and Administrator who indicated training was required to be completed for all new hires prior to working with residents and monthly training was conducted to ensure no trainings would expire. Allegation #8, linens are not properly cleaned was unsubstantiated based on observation of clean linen in all residents' rooms and interview with a Medication Technician and the Wellness Director who indicated resident linens were changed frequently and when soiled. The investigation into the allegation included: Observations of five residents' rooms, residents hygiene and appearance, visitation taking place, cleanliness of linens, residents clothing and personal items, presence of odors and medications being given to residents. Interviews with one Caregiver, a Medication Technician, the Wellness Director and the Administrator. Record review of six residents, including the resident of concern,			

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	physical exams, incident reports/changes in condition, activities of daily living and hospice notes. Document review of the facility's Admission Agreement, grievance reports, incident reports, Visitation policy, Personal Property policy and medication administration policy. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies identified. Please retain a copy for your records.			