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 _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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 09/08/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 65. The facility received a grade of A. The sample size was five. Five resident files and three employee files were reviewed. One complaint was investigated. Complaint #NV00066892 with ten allegations was substantiated. Allegation #1. The new Administrator is not properly trained and does not have proper credentials was substantiated. (See Tags Y0074 and Y1035). Allegation #2. The facility does not provide diabetic meals to residents who require them was substantiated. (See Tag Y0793) Allegation #3 - The facility does not follow its menu was substantiated based on three weekly menus that were undated and an interview with the Regional Director who revealed the facility was without an executive chef from mid-August to 09/08/22. (See Tag Y0272) The following allegations were substantiated without deficiency. Allegation #4 The facility has food shortages including milk and butter was substantiated without deficiency based on interviews with residents who indicated there were food shortages in the facility during the month of August 2022, however record review of food purchase orders for the months of July and August 2022 and observation of an appropriate amount of food on site revealed no concerns with food shortages. Interviews with kitchen staff indicated the facility maintained an ample supply of food on site. Allegation #5- The facility does not have any nursing staff was substantiated without deficiencies based on interview with the Regional Director who indicated the facility does not offer nursing services, employ nurses, and those services are provided by outside hospice	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JENNIFER DUNBAR Title: Regional Director Operation Date: 09/30/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
	services and home health services. Review of documentation revealed the facility is not required to maintain nursing staff. Allegation #6 - The facility does not have cooks and servers are being required to cook food for residents was substantiated without deficiency based on interviews with kitchen staff, Regional Director, and residents who indicated the kitchen was short on staff for a few weeks in mid-August 2022, which required servers to assist in cooking meals in the facility until more cooks were hired in the beginning of September 2022. The following allegations were unsubstantiated: Allegation #7 - The facility does not have any servers to serve food to the residents and some residents are not receiving meals was unsubstantiated based on observations of servers performing their job duties during breakfast and lunch. An interview with the Regional Director indicated in mid-August, several kitchen staff terminated employment, which resulted in servers performing food preparation duties to assist the facility, however residents continued to receive meals. Allegation #8 - Residents are purchasing food for other residents due to a lack of snacks was unsubstantiated based on record review of food purchase orders for the month of July and August 2022, which included snack items. Observation of the cold storage and pantry revealed the facility maintained snacks. An interview with two residents indicated they received snacks when they wanted them. Allegation #9 - All resident appointments have been canceled due to facility not having appropriate transportation was unsubstantiated based on observations of residents being transported to appointments via facility van and interviews with staff who indicated no residents had missed or had to reschedule an appointment due to a lack of transportation. Allegation #10 - The facility does not provide activities for the residents was unsubstantiated based on observations of staff led exercise with residents in the courtyard at 10:00 AM and staff led puzzle			

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 _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
	activity in the activity room at 11:20 AM. Documentation revealed a posted Activities Calendar for the month of September 2022 and was being followed. Allegation #11 - The facility did not have adequate staff and nobody was in charge was unsubstantiated based on interviews with residents who indicated receiving assistance, being appropriately cared for, and receiving meals and snacks throughout the day, an interview with the Regional Director who revealed several staff members terminated their employment at the facility and replacement staff engaged in the hiring process, and observation of staffing levels in the facility. Investigation into the allegations included: Observation of staffing levels in the facility, amount of food on-site, meal services, residents being transported, and activities in the facility. Interviews with two servers, Executive Chef, Administrator, Regional Director, and five residents. Record review of three employee files and five resident files. Document review of menus, activities calendar, food purchase orders, Resident Nutrition Services policy, and transportation 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:			
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate	0074	The Relias training program has been implemented to correct this deficiency. Relias requires all staff to complete elder abuse training within their 1st 40hrs of employment. The certificate of completion will be available in the employees Relias profile . Completion of the training will be monitored by the Business Office Manager. All current staff will have this completed by October 31st, 2022.	10/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
	such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
	abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home			

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 _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
	pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and record review, the facility failed to ensure Elder Abuse training was completed upon hire for 1 of 3 Employees (Employee #1). Employee #1 was hired on 08/25/22. The record of Employee #1 lacked documentation of Elder Abuse training. The facility was unable to provide documentation of Elder Abuse training for Employee #1. Severity: 2 Scope: 1			
0272 SS= D	Service of Food - Menus - NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. Inspector Comments: Based on observation, interview and document review, the facility failed to provide, date and post a menu. Findings include: On 09/08/22 at 9:45 AM, a Cook revealed the facility had been without an Executive Chef since mid-August 2022 and menus were not provided to residents during this time. ON 09/08/22, observation of three menus provided by the facility were not posted and lacked a date for which the meals listed would be served. On 09/08/22 at 1:30 PM, the Regional Director, Administrator, and Executive Chef acknowledged menus with the date should have been posted in the facility. Severity: 2 Scope: 1	0272	Menu's are now being implemented a week in advance, dated and posted within the dining room to correct the deficiency. The chef has been hired and is now responsible for preparing the menu a week in advance. For monitoring purposes, The Chef will provide copies to the Regional Director each meal prior to the week of the upcoming menu. This is in effect beginning today 09/26/2022	09/26/2022
0793 SS= D	Diabetes - Special Diet - NAC 449.2726 - Residents having diabetes 4. The caregivers of a residential facility with a resident who has diabetes and requires a special diet shall provide variations in the types of meals served and make available food substitutions in order to allow the resident to consume meals as prescribed by the resident's physician. The substitutions must conform with the recommendations for food exchanges contained in the "Exchange Lists For Meal Planning," published by the American Diabetes Association, Incorporated and the American Dietetic	0793	An Alternate meal option has been implemented on the menu and is reviewed by both the Chef and Regional Director prior to posting for healthy options to correct the deficiency. To ensure that the deficiencies do not recur, the menus are being created and approved by the VP of operations prior to being implemented in the communities. The Chef is responsible to ensure healthy options are available to residents at each meal service.	09/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
	Association, which is hereby adopted by reference. A copy of the publication may be obtained from the American Diabetes Association, Incorporated, Order Fulfillment Department, P.O. Box 930850, Atlanta, Georgia 31193-0850, at a cost of $2.50. Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure 1 of 5 residents (Resident #4) received a special diet. Findings include: Resident #4 (R4) R4 was admitted to the facility on 06/10/21, with diagnoses including Type II diabetes and hypertension. Review of a physician's order dated 06/10/21, documented R4 should be served a diabetic diet. On 09/08/22 at 9:45 AM, an interview with a cook revealed the facility did not have diabetic dietary options listed on their menus nor had a separate Diabetic Menu. A review of three undated menus provided by the Administrator revealed no diabetic dietary options for breakfast, lunch, and/or dinner. Review of the Resident Agreement revealed the facility will accommodate standard no-added-salt and no-concentrated sweets diets at no additional cost. On 09/08/22 at 1:20 PM, the Regional Director and Administrator acknowledged R4 should have been receiving diabetic dietary options at meals, the facility should have provided diabetic options on the menu, and all residents in the facility must have dietary needs met. Severity: 2 Scope: 1			

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 _____	**09/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF LAS VEGAS	**2320 IONE ROAD, LAS VEGAS, NEVADA ,89183**

(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
1035 SS= D	Care to Persons with Dementia - NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer ' s disease, and providing support for the members of the resident ' s family. Inspector Comments: Based on interview and record review, the facility failed to ensure two hours of Alzheimer's disease training was completed within the first 40 hours of employment for 1 of 3 Employees (Employee #1). Employee #1 was hired on 08/25/22. The record of Employee #1 lacked documentation of Alzheimer's disease training. The facility was unable to provide documentation of Alzheimer's disease training for Employee #1. Severity: 2 Scope: 1	1035	The Relias training program has been implemeted to correct this deificiency. Relias equires all staff to complete 2 hrs of ALZ training withing their 1st 40hrs of employment. The certificate of completion will be available in the employees Relias profile . Completion of the training will be monitored by the Business Office Manager. All current staff will have this completed by October 31st, 2022 and new staff on date of hire.	10/31/2022