

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11754	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER LAKEVIEW TERRACE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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

Title: Administrator

Date: 02/26/2026

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11754	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER LAKEVIEW TERRACE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005		
(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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 02/24/26. The facility is licensed for 86 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, and/or persons with Alzheimer's disease, and Assisted Living services, Category I and II residents. The census at the time of the survey was 69. Fifteen resident files and ten employee files were reviewed. The facility received a grade of A.			
Y 0220 SS= F	NAC 449.213 Laundry and linen services. 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen service shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one	Y 0220	(Y0220) 449.213 Immediately lint traps were cleaned from the first floor medication room and the two dryers in the first floor resident laundry room. Moving forward the signs will remain posted in the residents laundry room which reminds residents to clean trap after each use and the schedule for the Housekeepers on maintenance of machines. We will add a check off sheet for the Housekeeping staff to monitor for compliance. The Maintenance Director or designee will monitor daily for compliance. The Administrator and the Maintenance Director will be responsible to monitor the corrective action.	02/26/2026

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11754	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER LAKEVIEW TERRACE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005		
(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
	washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. 4. Clothes, bedding, linens and any other materials laundered pursuant to subsection 1 must be made clean by the laundering process. If a residential facility provides its own laundry and linen services, the residential facility shall: (a) Make appropriate use of detergents, soaps, heat or chemicals; and (b) Take precautions to ensure that no resident, member of the staff of the facility or other person in the facility is harmed by exposure to the detergents, soaps, heat or chemicals used in the laundering process. Inspector Comments: Based on observation and interview, the facility failed to ensure the lint traps of three clothes dryers were cleaned, creating a potential fire hazard. Findings include: On 02/24/26 at 9:26 AM, the lint trap of the dryer in the first floor medication room had layers of blue, gray and black lint. At 9:28 AM, the lint traps of the two dryers in the first floor resident laundry room each had a layer of lint. The Maintenance Director acknowledged the lint in the lint traps, and helped to dispose of the lint. On 02/24/26 at 9:28 AM, the Maintenance Director verbalized the three lint traps should have been cleaned after each load of laundry, and pointed out a prominent sign posted in the resident laundry room which			

Page 4 of 7

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11754	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER LAKEVIEW TERRACE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005		
(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
	diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident;			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11754	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER LAKEVIEW TERRACE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005		
(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
	(2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i) The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death.			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11754	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER LAKEVIEW TERRACE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 180 VILLE DRIVE, BOULDER CITY, NEVADA ,89005		
(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
	3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on interview and record review, the facility failed to ensure a tuberculosis (TB) screening was completed annually for 1 of 15 sampled residents (Resident #14). Resident #14 (R14) R14 was admitted on 01/15/24 with diagnoses including atrial fibrillation and hypertension. R14 had an annual TB screening completed on 11/20/24. R14's file lacked documented evidence of an annual TB screening for 2025 or 2026. On 02/24/26 in the morning, the facility was unable to provide documentation of an annual TB screening for R14. Severity: 2 Scope:1			