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 _____	**07/21/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT INN RESIDENTIAL CARE	**2845 BURNHAM AVENUE, LAS VEGAS, NEVADA ,89109**

(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 in your facility on 07/21/2025, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The census at the time of the survey was four. The sample size was four. The facility received a grade of A. There was one complaint investigated. Substantiated: Complaint #NV00074089 was substantiated. (See Tags Y0522 and Y0999) The investigation of Complaints included: Observation of grooming and physical appearance for residents and a tour of the facility. Interviews were conducted with residents, a Caregiver, and the Owner Record Review of four records, which included the resident of concern. Document Review included review of incident reports 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. The following regulatory deficiencies were identified:	0000		
0522 SS= G	Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 2. A person-centered service plan developed pursuant to this section must include, without limitation: (k) If the resident has Alzheimer ' s disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility, including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if:	0522	1. Person-Centered care plan was updated for R2, adding Protective Supervision Plan of Care. 2. Administrator will update plan of care if resident have changes in condition, behavior, elopement risk. Caregiver to report any changes on behavior and mental condition. 3. Administrator will monitor care of plan to ensure it is updated to reflect current condition, behavior or any changes in a resident to ensure their safety in the facility. 4. Administrator. 5. 7/22/25 6. Forms attached.	07/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: JASMINE CASTILLO Title: Administrator Date: 10/28/2025

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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	Inspector Comments: Based on interview, record review and document review the facility failed to ensure a resident who eloped from the facility was provided protective supervision according to the care plan (Resident #2). Findings include: Resident #2 (R2) R2 was admitted to the facility on 01/31/2025 with a diagnosis of Dementia. A care plan dated 02/01/2025, documented R2 required protective and cognitive supervision. An incident report dated 05/18/2025 documented at around 3:30pm there was a knock on the door. It was R2, R2 told the caregiver R2 climbed over the wall in the backyard to the (front side of the facility), and upon observation R2 was bleeding. The source of the bleeding was from the backside of R2's head. The Caregiver applied first aid and then called R2's primary care provider, and recommended R2 be brought to the acute care facility. On 08/21/2025 1:01pm, the Owner verbalized R2 went outside in the backyard of the facility to get some fresh air, and staff left R2 unsupervised. There was no documented evidence the facility updated the person-centered care plan after R2 eloped from the facility and was injured on 05/18/2025. The care plan was not updated to include how the facility would provide protective supervision post elopement. An incident report dated 05/25/2025 documented at around 6:00 AM the Caregiver received a phone call from the Administrator to confirm if R2 was still in R2's bedroom. The Caregiver checked and R2 was not in the bedroom. All doors were still locked from the inside of the facility. Upon further observation the Caregiver noticed the window in R2's bedroom and screen were broken. Later in the day the Caregiver asked R2 why R2 went out. R2 indicated going to the church on the other side of town. While R2 was walking, R2 tripped and fell and hit R2's face on the ground. R2 sustained a laceration above his left eyebrow that required stitches. R2 was treated at the acute care hospital and			

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	returned to the facility the same day on 05/25/2025. There was no documented evidence the facility updated the person-centered care plan after R2 eloped from the facility and was injured on 05/25/25. The care plan was not updated to include how the facility would provide protective supervision post elopement. On 08/21/2025, at 1:01pm, the Owner verbalized protective supervision of residents consisted of checking on them every 15 to 30 minutes to ensure safety. The Owner acknowledged R2 was not properly supervised, per the care plan. On 07/21/2025 in the morning, the Owner acknowledged R2's care plan had not been revised since 02/01/2025 and acknowledged it should have been revised after R2s' two elopement attempts. The facility's policy regarding wandering and elopement documented Caregivers were trained to continuously reassess the level of care needed, reconsider new behavior, re-channel disruptive behavior, redirect problem behavior and reassure the confused resident. They were to report any significant changes to the Administrator for action. Scope: 3 Severity: 1 CPT #NV00074089			

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observations and interviews the facility failed to ensure toxic substances were inaccessible to residents. Findings include: On 07/21/2025 in the morning, while conducting a tour of the facility substances which included paint, primer, bleach, and other cleaning products were observed on the back patio of the facility where residents had access. On 07/21/2025 in the morning, the Caregiver indicated the residents could access the back patio and verified the toxic substances should have been secured in the laundry area. On 07/21/2025 in the morning, the Owner acknowledged the residents could have accessed the toxic substances on the back patio, and indicated they should have been secured. Severity: 2 Scope: 3	0999	1. The caregiver put all the toxic substances in the laundry room and locked up. 2. Administrator reminded the caregiver to put all toxic substances in a locked cabinet or locked room, in this case the laundry room, after using it. 3. The administrator will monitor and check on the caregiver to put away toxic substances in the laundry room where it is locked after using them. 4. Administrator. 5. 7//21/2025 6. Photo attached.	07/21/2025