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 _____	**11/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	**10401 WEST CHARLESTON, LAS VEGAS, NEVADA ,89135**

(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 State Licensure annual and complaint investigation survey completed at your facility on 11/07/18. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for a total of 76 Residential Facility for Group beds which provides care to elderly and disabled persons and/or persons with mental retardation and/or assisted living services with 16 beds to provide care to persons with Alzheimer's Disease, Category II residents. The census at the time of the survey was 55. Fifteen resident files were reviewed and 15 employee files were reviewed. The facility received a grade of A One complaint was investigated NV00054569. Complaint #NV00054569 with the allegation of inappropriate placement of a resident and no medical waiver was substantiated (See Tag 825). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: DAVID CONAWAY Title: Administrator Date: 12/17/2018

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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0255 SS= E	449.217(6)(a)(b) - Permits - Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Health Division. Inspector Comments: Based on observation on 11/07/18, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. Cutting boards were stained and had deep abrasions. b. The ventilation hood filters on the cook's line were soiled with grease build-up. c. The kitchen floor was soiled with debris underneath equipment. d. The ground of the dumpster enclosure was soiled. Severity: 2 Scope: 2	0255	1. The identified cutting boards were replaced. The identified ventilation hood filters were taken down and cleaned free of any grease build-up. The identified kitchen floor areas was cleaned and debris was removed. The identified ground area of the dumpster enclosure has been cleaned and pressure washed. 2. A visual inspection of the cutting boards will occur monthly, the cutting boards will be replaced quarterly and/or on an as needed basis. The ventilation hood filters cleaning has been added to the master cleaning schedule to be completed weekly by the closing dishwasher and/or utility person. The kitchen floor area cleaning has been added to the master cleaning schedule for Tuesday and Saturday nights, completed by the closing dishwasher. The outside dumpster area cleaning has been added to the master cleaning schedule to be completed weekly by the closing dishwasher. 3. Audits of the identified areas will occur monthly for the first 90 days and quarterly thereafter. Administrator to monitor ongoing compliance. 4. The Director of dining services and/or designee will monitor for ongoing compliance. 5. All systemic measures for compliance completed by 12/14/18.	12/14/2018
0825 SS= D	449.2734(2)(c) - Pressure or Stasis Ulcers - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by a medical professional; residents having pressure or stasis ulcers. 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (c) Before a caregiver provides care to a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer,the caregiver must receive training related to the prevention and care of	0825	1. Re-reviewed resident closed record and identified wound waiver present in chart since 07/24/18. 2. An audit of all resident records was completed by the assisted living manager on 11/12/18 to ensure 100% compliance with wound waiver (preclusionary conditions) document signed by MD prior to or on the day of admission. 3. Audits to continue monthly for 90 days, quarterly thereafter and as needed. Assisted living manager and/or designee to complete. Administrator to monitor compliance ongoing. 4. Review and revise order of clinical	12/14/2018

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	pressure sores from a medical professional who is trained to provide care for that condition. Inspector Comments: Based on record review and interview, the facility failed to obtain a wound waiver for 1 of 15 sampled residents (Resident #15). Findings include: Resident #15 Resident #15 was admitted on 07/27/18,with diagnoses including pain, debility weakness and coronary artery disease. The resident's medical record lacked documented evidence a wound exemption waiver was obtained. A Progress Note dated 09/02/18, indicated the resident had an open wound on back and Coccyx. A Home Health/Hospice communication form documented the following: -On 08/24/18, the resident had midback 0.1 centimeter (cm) x 0.5 cm x 0.3 cm -On 08/31/18, buttocks now open please apply Calmoseptine -On 09/2/18, midback cleansed -On 09/04/18, the resident had new bedsores on buttocks -On 09/07/18, the resident had left and right buttocks applied duoderm, midback foam dressing. On 11/07/18 at 10:00 AM, a Medication Technician acknowledged the resident had wounds and had received care by Home Health agency three times a week. On 11/07/18 at 10:35 AM, a Manager was unaware if the resident had a wound waiver. The Manager indicated in order for a resident to receive wound care treatments, a Physician's order should have been obtained. The Manager indicated the facility did not have staff to treat wound care. On 11/07/18 at 10:42 AM, a Administrator acknowledged the resident did not have a wound exemption. The Administrator indicated the facility became aware of the resident's wounds by a family member. The Administrator explained he asked a Director of Nursing (DON) and a Rehabilition staff member to look at the resident's wounds after a family member complained. The Administrator indicated the Director of Nursing was not a staff member		records to clearly identify documents of this nature . Assisted living manager/Memory Care manager to complete. 5. All systemic measures for compliance complete by 12/14/18.	

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	at the facility. The Administrator indicated the resident was sent out to a local hospital during the assessment by the DON for shortness of breath. The Administrator indicated a Home Health agency had provided wound care treatments two to three times a week to the resident. The Administrator indicated there was no communication with the Home Health agency regarding the resident's wound care treatments. The Administrator indicated the Home Health agency had not addressed the resident's wound concerns appropriately. The Administrator indicated he had apologized to the resident's family and terminated services with the Home Health agency. Severity: 2 Scope:1			